

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08849

Within corporate limits

## 8859 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 4

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-hospital Permit. File Pages 1 or 2 with the registrar prior to burial, cremation, or removal.

D.O.A.

1. PLACE OF DEATH a. COUNTY <b>Allegany</b>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Md.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>		c. LENGTH OF STAY IN lb <b>64 yrs.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>at the Memorial Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <b>Dora</b>	Middle <b>Phyllis</b>	Last <b>Allen</b>
4. DATE OF DEATH	Month <b>Sept</b>	Day <b>26</b>	Year <b>1956</b>
5. SEX <b>Female</b>	6. COLOR OR RACE <b>colored</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 21-1892</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Domestic</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Housework</b>	9. AGE (In years last birthday) <b>64 yrs.</b>
13. FATHER'S NAME <b>Robert Massey</b>		11. BIRTHPLACE (State or foreign country) <b>Cumberland, Md.</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>218-30-0690</b>	17. INFORMANT <b>daughter Virginia Williams, Cumberland</b>
		Address <b>Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH <b>sudden</b>	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)  <b>422.1</b>		Myocardial failure	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		DUE TO (b) Chronic myo carditis DUE TO (c) Arteriosclerosis.	
3.1/2 yrs.		?	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <i>H.V. Deming M.D.</i>	DATE SIGNED <b>Sept. 27-1956</b>		
EXAMINER'S NAME (Type) <b>H.V. Deming M.D.</b>	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>Sept. 27, 1956</b>	22c. NAME OF CEMETERY OR CREMATORIAL <b>Summer Cem</b>	22d. LOCATION (City, town, or county) <b>Cumb. Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Louis Stein Inc. Cumb. Md.</i>	ADDRESS <i>Stein</i>	24a. RECEIVED BY REGISTRAR DATE <b>Sept. 28, 1956</b>	24b. REGISTRAR'S SIGNATURE <i>W.R. Tracy, M.D.</i>

BUREAU V. S

OCT 1 1956

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08851

Within corporate limit:

8860

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>MARYLAND</b>		b. COUNTY <b>ALLEGANY</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>		c. LENGTH OF STAY IN 1b <b>15 HRS. 35 MIN</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>		d. STREET ADDRESS <b>FREDERICK ST.</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Memorial Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)	First <b>ALBERT</b>	Middle <b>H</b>	Last <b>BANKS</b>	4. DATE OF DEATH	Month <b>SEPTEMBER</b>	Day <b>25</b>	Year <b>1956</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>COLORED</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH <b>JULY 13, 1892</b>	9. AGE (In years from birthdate) <b>64</b> yrs.	IF UNDER 1 YEAR Months <b>0</b>	IF UNDER 24 HRS. Days <b>0</b>	Hours <b>0</b>	Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Ewing Ret. Blrmkr</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>B. &amp; O Railroad</b>		11. BIRTHPLACE (State or foreign country) <b>Cumberland, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
13. FATHER'S NAME <b>EWING BANKS</b>		14. MOTHER'S MAIDEN NAME <b>MARGARET SHULER</b>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>705-10-6711</b>		17. INFORMANT <b>Mrs. Ethel Banks,</b>		<b>Benj. Banneker Homes</b> Address <b>Cumberland, Maryland</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>157X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)				<i>Convulsion of Paroxysm</i>		INTERVAL BETWEEN ONSET AND DEATH <b>1 yr.</b>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Young, 1955</b>		20f. (City or town) <b>Cumberland</b>		(County) <b>Cumberland</b> (State) <b>Maryland</b>
21. I certify that I attended the deceased from <b>Sept. 25, 1956</b> , to <b>Sept. 25, 1956</b> , that I last saw the deceased alive on <b>Sept. 25, 1956</b> , and that death occurred at <b>9:40 AM</b> , from the causes and on the date stated above.						ADDRESS (Street, city or town, state) <b>41 Bennett, Cumberland, Md.</b>		
ACTUAL SIGNATURE <i>B. M. Schindler</i>						DATE SIGNED <b>Sept. 28, 1956</b>		
PHYSICIAN'S NAME (Type) <b>B. M. Schindler</b>								
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Sept. 28, 1956</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Woodlawn Burial Park</b>		22d. LOCATION (City, town, or county) <b>Cumberland</b>		(State) <b>Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>John J. Hafer, Cumberland, Maryland</b>		ADDRESS		24a. REC'D BY REGISTRAR <b>Sept. 28, 1956</b>		24b. REGISTRAR'S SIGNATURE <b>W. R. Trentz, M.D.</b>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

**RECEIVED**

OCT 1 1956

**BUREAU V. S.**



20826 DEPARTMENT OF HOMELAND SECURITY - STATE - DIA/PEA

CERTIFICATE OF DEATH

SEARCHED	INDEXED
SERIALIZED	FILED
SEP 28 1956	
FBI - NEW YORK	
RECEIVED	

BUREAU N.Y.

SEP 28 1956

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8862

08852

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH o. COUNTY ALLEGANY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 8 DAYS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL MEMORIAL & WARWICK AVES.		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SWANTON	
3. NAME OF DECEASED (Type or print) GEORGE		Middle H.	Last BECKMAN
S. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH Dec. 25, 1872
		WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	SEPT. XXIX, 1872
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer, Retired		10b. KIND OF BUSINESS OR INDUSTRY Own Farm	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME THEODORE BECKMAN		14. MOTHER'S MAIDEN NAME LOUISE O'BRIEN	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 17. INFORMANT Address MEMORIAL HOSPITAL CUMBERLAND, MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 550.1 DUE TO <i>Reptileitis Generalized Adenitis</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO <i>Reptile Appendicitis</i> (c)		INTERVAL BETWEEN ONSET AND DEATH	
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>29 Aug</u> , 1956 to <u>6 Sept</u> , 1956, that I last saw the deceased alive on <u>6 Sept</u> , 1956, and that death occurred at <u>10:00P</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) ACTUAL SIGNATURE <u>Douglas B. Whitworth</u> M.D. <u>123 Bedford St.</u> PHYSICIAN'S NAME (Type) DR. F. B. WHITWORTH <u>Cumberland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9-9-56</u>	
22c. NAME OF CEMETERY OR CREMATORIAL <u>Royal Hill Cemetery</u>		22d. LOCATION (City, town, county) (State) <u>North Hale Garrett Co., Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Oscar F. Shapline</u>		24a. ADDRESS <u>Blaine, W. Va.</u>	
		24c. REC'D BY REGISTRAR <u>Sept. 9, 1956</u>	
		24b. REGISTRAR'S SIGNATURE <u>W. F. Frantz, M.D.</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU Y. S.

SEP 13 1956

REGELIV EU

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8927

08853

Reg. Dist. No.

## CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Allegany		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Md.		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westernport		b. COUNTY Allegany		
c. LENGTH OF STAY IN lb 72 Yrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westernport		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 244 Main		d. STREET ADDRESS 244 Main		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)	First Delphia	Middle Burns	Last Biddle	
4. DATE OF DEATH	Sept	Month	Day 24	
		Year 1956		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1887 22 Feb. 1956	
9. AGE (In years last birthday) 72 yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days	12. IF UNDER 24 HRS. Hours	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife	10b. KIND OF BUSINESS OR INDUSTRY own home	11. BIRTHPLACE (State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Charles Dayton	14. MOTHER'S MAIDEN NAME Thomzine Pierce	Address		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no	16. SOCIAL SECURITY NO.	17. INFORMANT Louis Biddle	18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)  260X Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.  DUE TO (b)  DUE TO (c)	INTERVAL BETWEEN ONSET AND DEATH 1/2 hr.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) Westernport	(County)	(State)		
21. I certify that I attended the deceased from 1/1/1946 to 9/24/56, that I last saw the deceased alive on 9/24/56, and that death occurred at Westernport, Md., from the causes and on the date stated above.				
ACTUAL SIGNATURE P. E. BERRY	ADDRESS (Street, city or town, state) Piedmont W. Va DATE SIGNED 9/25/56			
PHYSICIAN'S NAME (Type) P. E. BERRY				
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 9/26/56	22c. NAME OF CEMETERY OR CREMATORIUM Philos Cem.	22d. LOCATION (City, town, or county) (State) Westernport, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE El. Boral	ADDRESS Westernport, Md.	24a. REC'D BY REGISTRAR DATE 9-25-56	24b. REGISTRAR'S SIGNATURE Jean C Kelly	

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please return carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



8863

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b>		b. COUNTY <b>ALLEGANY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>		c. LENGTH OF STAY IN lb <b>7 HRS.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>LA VALE</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MEMORIAL HOSPITAL MEMORIAL &amp; WARWICK AVES.,</b>				d. STREET ADDRESS <b>B. ST. RT.#1,</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <b>HENRY</b>	Middle <b>W</b>	Last <b>BOCH</b>	4. DATE OF DEATH	Month <b>SEPTEMBER</b>	Day <b>18</b>	Year <b>1956</b>
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <b>JAN. 8 1909</b>	9. AGE (In years from last birthday) <b>47</b>	IF UNDER 1 YEAR yrs. <b>Months Days Hours Min.</b>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Private Garbage Hauling</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Self-employed</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>A.S.A.</b>	
13. FATHER'S NAME <b>FRANK BOCH</b>		14. MOTHER'S MAIDEN NAME <b>MARY O'BAKER</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>214-07-4770</b>		17. INFORMANT <b>Memorial Hosp. Records. Cumberland</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]  PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Spontaneous Pneumothorax with hemorrhage into rt. pleural cavity</b>		INTERVAL BETWEEN ONSET AND DEATH <b>6 hrs</b>					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  —					
20c. TIME OF INJURY Hour a. m. p. m.	Month 19	Doy	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <b>Cumberland, Md.</b>	(County)	(State)
21. I certify that I attended the deceased from <b>9/17/56</b> , 19, to <b>9/18/56</b> , 19, that I last saw the deceased alive on <b>9/19/56</b> , 19, and that death occurred at <b>7:35 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Cumberland, Md.</b> DATE SIGNED <b>Richard J. Williams</b> M.D. <b>9/18/56</b>							
ACTUAL SIGNATURE		PHYSICIAN'S NAME (Type) <b>RICHARD J. WILLIAMS</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>Sept 21-1956</b>	22c. NAME OF CEMETERY OR CREMATORIUM <b>S.S. Peter &amp; Paul Cem.</b>		22d. LOCATION (City, town, or county) <b>Cumberland Md.</b>		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Louis Stein Inc.</b>		ADDRESS <b>Cumberland Md.</b>		24a. REC'D BY REGISTRAR <b>Sept. 20, 1956</b>	24b. REGISTRAR'S SIGNATURE <b>W.H. Brantley, M.D.</b>		

BUREAU U. S.

SEP 24 1956

**REGEI V ED**

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08855  
6

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) o. STATE Md. b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Franklin		c. LENGTH OF STAY IN lb 32 yrs	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Marian		First	Middle
			Last
		Bosley	4. DATE OF DEATH Sept
		Month 26	Day Year 1956
S. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 22 Mar. 1878
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife		10b. KIND OF BUSINESS OR INDUSTRY Own home	11. BIRTHPLACE (State or foreign country) West Va.
13. FATHER'S NAME Daniel Schell		14. MOTHER'S MAIDEN NAME Mary Cosner	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	17. INFORMANT Address Paul Bosley Westernport, Md.
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.2 DUE TO Chronic Myocarditis and Myocardial Degeneration Not Specified as Rheumatic INTERVAL BETWEEN ONSET AND DEATH 2 Years			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		(b) DUE TO	
		(c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) None	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Jan 25</u> , 1955, to <u>Sept 26</u> , 1956, that I last saw the deceased alive on <u>Sept 26</u> , 1956, and that death occurred at <u>Piedmont W. Va.</u> ADDRESS (Street, city or town, state) <u>Piedmont, W. Va.</u> DATE SIGNED <u>Sept 28, 1956</u>			
ACTUAL SIGNATURE <u>Paul Wilson</u>		M.D.	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/29/56	22c. NAME OF CEMETERY OR CREMATORIAL Philos
22d. LOCATION (City, town, or county) Westernport		(State) Md.	
23. FUNERAL DIRECTOR'S SIGNATURE <u>E.S. Boal</u>		ADDRESS Westernport, Md.	24a. REC'D BY REGISTRAR DATE 9-30-56
		24b. REGISTRAR'S SIGNATURE <u>Jeon C Kelly</u>	

**RECEIVED**

OCT 3 1956

**BUREAU V. S**

Within this  
corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08856

8864

CERTIFICATE OF DEATH

Reg. Dist. No. 4

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AUSC 155 10M

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY Allegany CITY (If outside corporate limits, write RURAL OR end give nearest town) TOWN Cumberland		MARYLAND LENGTH OF STAY (in this place)	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 935 Gay St.,		STATE Maryland CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland STREET ADDRESS 935 Gay St.,	
3. NAME OF DECEASED (Type or Print) BESSIE		(First) (Middle) (Last) BOYLAND	
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed	8. DATE OF BIRTH Sept. 14, 1884
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own home	
13. FATHER'S NAME Nelson Miller		14. MOTHER'S MAIDEN NAME Emma Unble	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No,		16. SOCIAL SECURITY NO. 214-16-2243	
17. INFORMANT & ADDRESS Mr. Raymond E. Boyland 935 Gay St., Cumberland, Md.			
18. MEDICAL CERTIFICATION <i>Myocardial Failure Arteriosclerotic heart Disease Generalized Rheumatoid Arthritis - Disease Generalized arteriosclerosis</i>			
19a. DATE OF OPERATION no.			
19b. MAJOR FINDINGS OF OPERATION no.			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) none		21e. INJURY OCCURRED M. While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR? <i>July 14, 1956, 1:30 PM</i>			
22. I hereby certify that I attended the deceased from <i>July 14, 1956</i> to <i>July 14, 1956</i> , that I last saw the deceased alive on <i>July 14, 1956</i> , and that death occurred at <i>1:30 PM</i> , M., from the causes and on the date stated above. SIGNATURE <i>John S. Miller, M.D.</i> ADDRESS (Street, city, town, state) <i>140 Bedford St, Cumberland, Md.</i> DATE SIGNED <i>July 14, 1956</i>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 9/15/56	NAME OF CEMETERY OR CREMATORIUM Davis Memorial Cemetery
24. REC'D BY REGISTRAR Date <i>Sept. 14, 1956</i>		REGISTRAR'S SIGNATURE Winter R. Frank, M.D.	LOCATION (City, town, or county) Cumberland, Maryland
25. FUNERAL DIRECTOR'S SIGNATURE Charles L. George Cumberland, Md.			

BY DIRECTIVE OF THE SECRETARY OF STATE - 1956

STANDARD OF DEBT

BUREAU V.  
RECEIVED  
SEP 18 1956

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8928

08857

## CERTIFICATE OF DEATH

Reg. Dist. No. 9

1. PLACE OF DEATH o. COUNTY <b>Allegany</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b>		b. COUNTY <b>Allegany</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frostburg</b>		c. LENGTH OF STAY IN 1b <b>Lifetime</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frostburg</b>		d. STREET ADDRESS <b>266 East Main, Frostburg</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>JAMES</b>		First	Middle <b>H.</b>	Last <b>BRADY</b>	4. DATE OF DEATH Month <b>9</b> Day <b>13</b> Year <b>1956</b>	Month	Day
S. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	B. DATE OF BIRTH <b>7/13/1875</b>	9. AGE (In years lost birthday) <b>81 yrs.</b>	IF UNDER 1 YEAR Months <b>81</b>	IF UNDER 24 HRS. Days <b>0</b>	Hours <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Helper</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Perry Point Veteran Hospital</b>		11. BIRTHPLACE (State or foreign country) <b>Eckhart Mines</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Patrick Brady</b>		14. MOTHER'S MAIDEN NAME <b>Honora Kenny</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> None		16. SOCIAL SECURITY NO. <b>214-01-6694</b>		17. INFORMANT <b>Miss Catherine Brady, Frostburg, Md.</b>		26. ADDRESS <b>266 E. Main</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>450.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>(b)</b> DUE TO <b>(c)</b>		<b>Acute Cardiac Dilatation</b>		<b>8 hrs</b>		INTERVAL BETWEEN ONSET AND DEATH <b>—</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>167 E Main</b>		20f. (City or town) <b>Frostburg</b>		(County) <b>W.M.C.</b>	(State) <b>MD</b>
21. I certify that I attended the deceased from <b>Sept 12, 1956</b> , to <b>Sept 13, 1956</b> , that I last saw the deceased alive on <b>Sept 12, 1956</b> , and that death occurred at <b>5:15 P.M.</b> from the causes and on the date stated above. ACTUAL SIGNATURE <b>W.M.C. Lane</b>		ADDRESS (Street, city or town, state) <b>167 E Main</b>		DATE SIGNED <b>9-14-56</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>9/15/56</b>		22c. NAME OF CEMETERY OR CREMATORIAL <b>St. Michael's Cemetery</b>		22d. LOCATION (City, town, or county) <b>Frostburg</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Hafer Funeral Home</b>		ADDRESS <b>23 E. Main, Frostburg</b>		24a. REC'D BY REGISTRAR <b>9-15-56</b>		24b. REGISTRAR'S SIGNATURE <b>Laurey N. Rose</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event, within 72 hours after death.

EXCELSIOR STATE GOVERNMENT - SALINAS

CERTIFICATE OF DEATH

BUREAU X.

SEP 21 1956

RECEIVED

Within corporate limits

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 8865 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08858

Reg. Dist. No. 4

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the registrar prior to burial or removal.

1. PLACE OF DEATH a. COUNTY <b>Allegany</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE <b>Md.</b> b. COUNTY <b>Allegany</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>		c. LENGTH OF STAY IN lb <b>55 yrs.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>at the Sacred Heart Hospital.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <b>Ralph</b>	Middle <b>Randolph</b>	Last <b>Brant</b>
4. DATE OF DEATH	Month <b>Sept.</b>	Day <b>21</b>	Year <b>1956</b>
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 15-1901</b>
9. AGE (In years last birthday) <b>55 yrs.</b>	10. IF UNDER 1 YEAR Months <b>0</b>	11. IF UNDER 24 HRS. Days <b>0</b>	12. IF UNDER 24 HRS. Hours <b>0</b> Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer- Queen City Brewing Co.</b>		11. BIRTHPLACE (State or foreign country) <b>Cumberland, Md.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Norman Brant</b>	
14. MOTHER'S MAIDEN NAME <b>Viletta Ritter Pitzer</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) If yes, give war or dates of service) <b>no</b>	
16. SOCIAL SECURITY NO. <b>214-05-5699</b>		17. INFORMANT <b>(wife) Hazel Moreland Brant, Cumberland, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary occlusion</b>			
DUE TO <b>420.1</b>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Coronary sclerosis</b>			
DUE TO (c) ?			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(c)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <i>H.V. Deming M.D.</i>	DATE SIGNED		
EXAMINER'S NAME (Type) <b>H.V. Deming M.D.</b>	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		
	ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		
	DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Sept. 22-1956		
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>Sept. 24, 1956</b>	22c. NAME OF CEMETERY OR CREMATORIAL <b>Zion Memorial Burial Park</b>	22d. LOCATION (City, town, or county) (State) <b>Cumberland, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>William H. Kight, Cumberland, Maryland.</b>	ADDRESS <b>Kight</b>	24a. REC'D BY REGISTRAR <b>Sept. 22, 1956 W.H. Kight, M.D.</b>	24b. REGISTRAR'S SIGNATURE

**RECEIVED**

SEP 26 1956

**BUREAU V. S.**

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08858

8929

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY  Allegany		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Garrett	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg	c. LENGTH OF STAY IN 1b 3 days	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Miners Hospital		d. STREET ADDRESS Route 2	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First ISABELLE	Middle (KNOX)	Last BROADWATER
4. DATE OF DEATH	Month Sept.	Day 25,	Year 19 56
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-12-1884
9. AGE (In years lost birthday) 72 yrs.		10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housework		10b. KIND OF BUSINESS OR INDUSTRY own home	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Simon Knox		14. MOTHER'S MAIDEN NAME Caroline Brown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/>		16. SOCIAL SECURITY NO. none	
17. INFORMANT Cecil Broadwater, Rt. 2, Frostburg, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 590X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 2 weeks	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 260X Diabetes		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Sept 21, 1956, to Sept 25, 1956, that I last saw the deceased alive on Sept 24, 1956, and that death occurred at 5:45 AM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) ACTUAL SIGNATURE WOM Lane M.D.			
DATE SIGNED Frostburg Md. Sept 26 1956			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-27-56	
22c. NAME OF CEMETERY OR CREMATORIUM Robinson Cemetery		22d. LOCATION (City, town, or county) Avilton, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE J. R. Durst, Frostburg, Md.		24a. REC'D BY REGISTRAR DATE 9-27-56	
		24b. REGISTRAR'S SIGNATURE Dee Daucy N.R.P.	

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death: Page 4  
 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



Within corporate limits

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending", in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director and 4 should be forwarded to the Chief Medical Examiner's Office along with farm PM3. Page 5 may be retained for your files.  
**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the registrar prior to burial or removal.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 8866 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08860

Reg. Dist. No. 4

1. PLACE OF DEATH a. COUNTY <b>Allegany</b>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) b. STATE <b>Md.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>		c. LENGTH OF STAY IN 1b <b>20 yrs</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>D.O.A. at Memorial Hospital</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>	
3. NAME OF DECEASED (Type or print)	First <b>Conrad</b>	Middle <b>E</b>	Last <b>Brookley</b>
S. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <b>Nov. 18-1894</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Draftsman</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Celanese Corp.</b>	11. BIRTHPLACE (State or foreign country) <b>Portage, Pa.</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>Conrad Brookley</b>		14. MOTHER'S MAIDEN NAME <b>Josephine Schwab</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>W.W.1 214-07-1674</b>	17. INFORMANT <b>(son) Charles A. Brookley, Cumberland, Md</b>
Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary occlusion</b> about <b>1.1/2 hrs.</b>			
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Coronary sclerosis</b> 1 yr.			
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m.		Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <i>H. V. Deming M.D.</i>	DATE SIGNED M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Sept. 19-1956		
22a. BURIAL, CREMATION OR REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>Sept. 21, 1956</b>	22c. NAME OF CEMETERY OR CREMATORIUM <b>Hillcrest Burial Park</b>	22d. LOCATION (City, town, or county) <b>Cumberland, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>John J. Hafer, Cumberland, Maryland.</b>	ADDRESS <i>John J. Hafer, Cumberland, Maryland.</i>	24a. REC'D BY REGISTRAR <i>Sept. 20, 1956</i>	24b. REGISTRAR'S SIGNATURE <i>W. L. Frantz M.D.</i>

RECEIVED  
FBI BUREAU WASH D C

SEP 24 1956

Within corporate limits

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08861

8867

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH a. COUNTY <b>Allegany</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Allegany</b>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>		c. LENGTH OF STAY IN 1b <b>4 hrs.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>		d. STREET ADDRESS <b>216 Carroll Street</b>					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Sacred Heart Hospital</b>						e. IS RESIDENCE ON A FARM? / YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)	First <b>Alma</b>	Middle <b>B.</b>	Last <b>Brooke</b>	4. DATE OF DEATH	Month <b>Sept.</b>	Day <b>16</b>	Year <b>1956</b>				
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1904</b>	9. AGE (In years last birthday) <b>52 yrs.</b>	IF UNDER 1 YEAR Months <b>0</b>	IF UNDER 24 HRS. Days <b>0</b>	Hours <b>0</b>	Min. <b>0</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (State or foreign country) <b>Romney W. Va.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>					
13. FATHER'S NAME <b>Thomas Bartlett</b>				14. MOTHER'S MAIDEN NAME <b>Nellie Singleton</b>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? {Yes, no, or unknown} <b>No</b>				16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Chart</b>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]  PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hypertension C.V. Disease</b> <b>581.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. <b>Ob-Cirrhosis</b> (b) DUE TO (c)  PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									INTERVAL BETWEEN ONSET AND DEATH <b>year</b>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)									20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20c. TIME OF INJURY Hour a. m. p. m.	Month 19	Day	Year	20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <b>West 16</b>	(County) <b>1956</b>	(State)			
21. I certify that I attended the deceased from <b>January</b> , 1956, to <b>Sept. 16</b> , 1956, that I last saw the deceased alive on <b>Sept. 16</b> , 1956, and that death occurred at <b>M.</b> from the causes and on the date stated above. ACTUAL SIGNATURE <b>B. M. Schindler</b> M.D.									ADDRESS (Street, city or town, state)	DATE SIGNED <b>9/18/56</b>	
PHYSICIAN'S NAME (Type) <b>B. M. Schindler, M.D.</b>									Green St., Cumberland, Md.		
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>9/19/56</b>	22c. NAME OF CEMETERY OR CREMATORIUM <b>Romney Colored Cem</b>		22d. LOCATION (City, town, or county) <b>Romney, West Virginia</b>			(State)				
23. FUNERAL DIRECTOR'S SIGNATURE <b>Hafer Funeral Service, Cumberland, Md.</b>				ADDRESS <b>Cumberland, Md.</b>	24a. REC'D BY REGISTRAR <b>Sept. 19, 1956</b>	24b. REGISTRAR'S SIGNATURE <b>W. H. Hafer, M.D.</b>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. A  
REGEL V EDO

SEP 21 1956

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 Item 8 Film G202 9-10-56 et CERTIFICATE OF DEATH												Reg. Dist. No. 08862			
1. PLACE OF DEATH a. COUNTY 8868 MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany											
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland 59 Days				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland											
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Sacred Heart Hospital				d. STREET ADDRESS 705 Lincoln St.											
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>															
3. NAME OF DECEASED (Type or print) First Middle Last				4. DATE OF DEATH Month Day Year											
Edith Bruner				Sept. 1 1956											
S. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 28, 1875	9. AGE (In years last birthday) 80 yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.											
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Own Home				11. BIRTHPLACE (State or foreign country) Maryland				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Henry Fisher (deceased)				14. MOTHER'S MAIDEN NAME Ella Smith (deceased)											
15. WAS DECEASED EVER IN U. S. ARMED FORCES? No (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. None				17. INFORMANT Karl Fisher (brother) Bedford #1, Pa. Address							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>420.0</i> DUE TO <i>Cerebral Hemorrhage</i> MULTIPLE INTERVAL BETWEEN ONSET AND DEATH 5 mo.															
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Arteriosclerotic Thart Disease</i> DUE TO 20 yr.															
(c) <i>Generalized Arteriosclerosis</i> DUE TO 20 yr.															
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Advanced age</i>												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.) <i>None</i>											
20c. TIME OF INJURY Month, Day, Year Hour o.m. 19 p.m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Home</i>				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 7-4-56, 19, to 9-1-56, 19, that I last saw the deceased alive on 9-1-56, 19, and that death occurred at 11:00 P.M., from the causes and on the date stated above. ACTUAL SIGNATURE <i>J.P. Hallinan M.D.</i> ADDRESS (Street, city or town, state) <i>140 Bedford St., Cumberland, Maryland.</i> DATE SIGNED <i>9-1-56</i>															
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial Sept. 4, 1956				22b. DATE THEREOF				22c. NAME OF CEMETERY OR CREMATORIUM Bethel Cemetery				22d. LOCATION (City, town, or county) (State) Near) Centerville, Pa.			
23. FUNERAL DIRECTOR'S SIGNATURE <i>G. W. Right</i>				ADDRESS <i>Cumberland, Md.</i>				24a. REC'D BY REGISTRAR				24b. REGISTRAR'S SIGNATURE <i>W. L. Tracy, M.D.</i> DATE <i>Sept. 4, 1956</i>			
VS A15 (4) 1SM 9/55															

BUREAU X-2  
REGIME

SEP 6 1956

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Outside of  
City Limits

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08863

8942

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

PLACE OF DEATH a. COUNTY <b>Allegany</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Allegany</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Cumberland</b>		c. LENGTH OF STAY IN lb <b>Yrs.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Cumberland</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>R. D. #1 Cumberland</b>		d. STREET ADDRESS <b>R.D. #1 Cumberland</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Mary</b>		First <b>Josephine</b>	Middle <b>Buchholtz</b>	Last <b></b>	4. DATE OF DEATH <b>Sept. 30,</b>	Month <b>19 56</b>	Day <b></b>
S. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 16, 1886</b>	9. AGE (In years last birthday) <b>70 yrs.</b>	10. IF UNDER 1 YEAR Months <b></b>	11. IF UNDER 24 HRS. Days <b></b>	12. IF UNDER 24 HRS. Hours <b></b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Part Owner</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Gas Business</b>		11. BIRTHPLACE (State or foreign country) <b>Cumberland, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>William A. Buchholtz</b>				14. MOTHER'S MAIDEN NAME <b>Elizabeth C. Maus</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>214-32-3286</b>		17. INFORMANT <b>Mr. Paul Buchholtz</b>		Address <b>Cumberland, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Maligual Cachexia</b> DUE TO <b>199.1</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO <b>Growth in fulvis</b> (c) INTERVAL BETWEEN ONSET AND DEATH <b>4 mos</b> <b>1 year</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Myocarditis &amp; Endocarditis with Natrial</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b></b>		20f. (City or town) (County) (State) <b></b>	
21. I certify that I attended the deceased from <b>Sept. 26, 1956</b> , to <b>Sept. 30, 1956</b> , that I last saw the deceased alive on <b>Sept. 30, 1956</b> , and that death occurred at <b>7:30 AM</b> , from the causes and on the date stated above. ACTUAL SIGNATURE <b>F. Alan G. Murray</b> M.D. ADDRESS (Street, city or town, state) <b>La Vale</b> DATE SIGNED <b>Oct. 1-56</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>10-2-1856</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>S.S. Peter &amp; Paul Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Cumberland, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Charles L. George</b>				ADDRESS <b>Cumberland, Md.</b>		24a. REG'D BY REGISTRAR DATE <b>Oct. 21-56</b>	
						24b. REGISTRAR'S SIGNATURE <b>W.P. Murray, M.D.</b>	

BUREAU V.

OCT 3 1956

REGELIV ED

1  
Within corporate limits

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

08864

## 8869 CERTIFICATE OF DEATH

Reg. Dist. No. 4

## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

## 1. PLACE OF DEATH

COUNTY Allegany  
 CITY (If outside corporate limits, write RURAL  
 OR end give nearest town)  
 TOWN Cumberland

HOSPITAL OR  
 INSTITUTION OR  
 STREET ADDRESS Allegany County Infirmary

MARYLAND

LENGTH OF STAY  
(in this place)  
11/23/53

## 2. USUAL RESIDENCE (HOME) OF DECEASED

STATE Maryland COUNTY Allegany  
 CITY (If outside corporate limits, write RURAL and give nearest town)  
 OR TOWN Cumberland

STREET ADDRESS (If rural give location)  
537 Greenway Avenue

3. NAME OF  
DECEASED  
(Type or Print)

Agnes

C.

Buskey

(First)

(Middle)

(Last)

4. DATE (Month)

(Day)

(Year)

OF  
DEATH

September 7, 1956

5. SEX

6. COLOR OR  
RACE7. SINGLE, MARRIED,  
WIDOWED, DIVORCED,  
(Specify)

8. DATE OF BIRTH

9. AGE last birthday

IF UNDER 1 YEAR

Months Deys Hours Min.

Female

White

Single

11/1/1909

486 - 46 yrs.

10e. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if  
Laundry worker -10b. KIND OF BUSINESS  
OR INDUSTRY

Memorial Hosp. P. C. Cumberland, Maryland

12. CITIZEN OF WHAT  
COUNTRY?

U. S. A.

13. FATHER'S NAME

Joseph Buskey

14. MOTHER'S MAIDEN NAME

Catherine C. McDonald

15. WAS DECEASED EVER IN U. S. ARMED FORCES?

(Yes, no, or unk.)

(If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT &amp; ADDRESS

Allegany County Infirmary Records

## 18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

IMMEDIATE CAUSE (A) Pulmonary Hypertension 48 hrs.  
 ANTECEDENT CAUSE(S) DUE TO Chronic Bronchitis ?  
 DISEASES OR CONDITIONS, IF ANY, (B) GIVING RISE TO THE ABOVE CAUSE Chronic Zephritis ?  
 STATING UNDERLYING CAUSE LAST. DUE TO Arthritis Deforecaus ?

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING DEATH.INTERVAL BETWEEN  
ONSET AND DEATH

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES  NO 21a. ACCIDENT WAS UNDERLYING   
OR CONTRIBUTING  CAUSE OF DEATH  
(If either, NOTIFY MEDICAL EXAMINER)21b. PLACE (Home, farm, factory,  
OF INJURY street, office bldg., etc.)

21c. WHERE DID INJURY OCCUR? (City or town)

(County)

(State)

21d. TIME OF INJURY (Month)

(Day)

(Year)

(Hour)

21e. INJURY OCCURRED

While  
at work  Not while  
at work 

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 11/23/53, 19....., to 9/7/56, 19....., that I last saw the deceased  
alive on 9/7/56, 19....., and that death occurred at 10:40A, from the causes and on the date stated above.

SIGNATURE Dr. James E. McLean

ADDRESS (Street, city, town, state)

DATE SIGNED  
9/7/5623. BURIAL, CREMATION,  
REMOVAL (SPECIFY)

Burial

DATE THEREOF

9/10/56

NAME OF CEMETERY OR CREMATORI

S. S. Peter &amp; Paul's

LOCATION (City, town, or county)

Cumberland, Maryland

(State)

24. REC'D BY REGISTRAR

Sept. 9, 1956

REGISTRAR'S SIGNATURE

Winter R. Frank, M.A.

25. FUNERAL DIRECTOR'S SIGNATURE

Charles L. George Cumberland, Md.

ADDRESS

DEPARTMENT OF HEALTH-ENVIRONMENTAL QUALITY  
STATE OF MARYLAND

CERTIFICATE OF DATA

Environmental

Water Quality

Monitoring

Water Quality

Water Quality

Monitoring

RECEIVED

SEP 13 1956

RECEIVED

Within corporate limits

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08865

DR. HODGES

8870

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY ALLEGANY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 CUMBERLAND		c. LENGTH OF STAY IN 1b 5 MINUTES				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)	First PAMELA	Middle CLARK	Last			
4. DATE OF DEATH	Month SEPTEMBER	Day 13, 1956	Year 56			
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	B. DATE OF BIRTH MAY 18, 1956			
WIDOWED <input type="checkbox"/>	DIVORCED <input type="checkbox"/>	9. AGE (In years lost birthday) yrs. Months 3 Days 25 Hours Min.	IF UNDER 1 YEAR Hours 25			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE		10b. KIND OF BUSINESS OR INDUSTRY None	11. BIRTHPLACE (State or foreign country) CUMBERLAND, MARYLAND			
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME JULIAN CLARK				
14. MOTHER'S MAIDEN NAME JACQUELYN SPARGO		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO				
16. SOCIAL SECURITY NO. None		17. INFORMANT MEMORIAL HOSPITAL - CUMBERLAND, MD.				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]  PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 204.1 DUE TO  Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 6 weeks				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Hour o. m. p. m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 8177	20f. (City or town) 9121	(County) 1956	(State)
21. I certify that I attended the deceased from alive on 9/19/54, to 9/17/56, and that death occurred at 2:10 A.M., from the causes and on the date stated above.		ADDRESS (Street, city or town, state) Cumberland, Md. DATE SIGNED 5/21/56				
ACTUAL SIGNATURE W.R. Hodges	M.D.					
PHYSICIAN'S NAME (Type) Burial	22b. DATE THEREOF 9/15/56	22c. NAME OF CEMETERY OR CREMATORIUM St. Marys' Cemetery	22d. LOCATION (City, town, or county) Cumberland, Maryland	(State)		
23. FUNERAL DIRECTOR'S SIGNATURE Charles L. George	ADDRESS Cumberland, Maryland	24a. REG'D BY REGISTRAR DATE Sept. 14, 1956	24b. REGISTRAR'S SIGNATURE R.W. Frank, M.D.			

## CERTIFICATE OF DEATH

Date of Birth

Date of Death

Cause of Death

Place of Death

Date of Issue

Name of Deceased

Age at Death

Cause of Death

Sex

Race

Cause of Death

Color

Cause of Death

BUREAU V. S.

SEP 18 1956

RECEIVED

**INSTRUCTIONS**  
**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 72 hours after death.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 155 10W

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08866

## 8943 CERTIFICATE OF DEATH

Reg. Dist. No. 6

<b>1. PLACE OF DEATH</b>			<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>		
COUNTY CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN		MARYLAND LENGTH OF STAY (in this place)	STATE CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN		COUNTY Allegany
McCoole			McCoole		
HOSPITAL OR INSTITUTION OR STREET ADDRESS 70 Howard St.			STREET ADDRESS 70 Howard St.		
<b>3. NAME OF DECEASED</b> (First) Rose (Middle) Ravenscroft (Last) Clark			<b>4. DATE OF DEATH</b> Sept. 17 1956		
S. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widow	8. DATE OF BIRTH Dec. 26, 1880	9. AGE last birthday 75 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Dawson, Md.	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Thomas Ravenscroft			14. MOTHER'S MAIDEN NAME Elizabeth Dayton		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) No		16. SOCIAL SECURITY NO. None		17. INFORMANT & ADDRESS Mrs. Robert May, McCoole, Md.	
<b>I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>					
443X IMMEDIATE CAUSE (A) Pulmonary edema.					
ANTECEDENT CAUSE(S) DUE TO (B) Myocarditis.					
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) Hypertension - myocarditis.					
<b>II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>					
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION			
<b>19c. MEDICAL CERTIFICATION</b>					
INTERVAL BETWEEN ONSET AND DEATH 9/17-56					
Feb 1955					
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
<b>22. I hereby certify that I attended the deceased from....., 1953, to 9-17, 1956, that I last saw the deceased alive on.....9-17, 1956, and that death occurred at 6 A.M., from the causes and on the date stated above.</b>					
SIGNATURE <i>Chiffi M.D.</i> ADDRESS (Street, city, town, state) <i>Kyser W Va</i> DATE SIGNED <i>9-17-56</i>					
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF Sept. 19/56		NAME OF CEMETERY OR CREMATORIUM Dayton Cemetery	
24. REC'D BY REGISTRAR DATE 9-18-56		REGISTRAR'S SIGNATURE <i>Jean C Kelly</i>		LOCATION (City, town, or county) (State) Dawson, Md. ADDRESS <i>Brownwood, Keyser, W. Va.</i>	
25. FUNERAL DIRECTOR'S SIGNATURE					

STATE OF NEVADA - CAPITAL CITY

STATE OF NEVADA - CAPITAL CITY

BUREAU V. A.

SEP 24 1956

RECEIVED

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4  
may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8930

## CERTIFICATE OF DEATH

08867

Reg. Dist. No. 6

1. PLACE OF DEATH o. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) o. STATE	
All Allegany MARYLAND		Md.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westernport		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westernport	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 307 Rock		d. STREET ADDRESS 307 Rock	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First	Middle
Russell Henry			Coleman
4. DATE OF DEATH		Month	Day
Sept 3 1956		1956	19
5. SEX		6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
Male		White	B. DATE OF BIRTH 28 Feb. 1863
8. AGE (In years last birthday) 93 yrs.		9. IF UNDER 1 YEAR Months	10. IF UNDER 24 HRS. Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Paper Finisher		10b. KIND OF BUSINESS OR INDUSTRY Paper Mill	11. BIRTHPLACE (State or foreign country) W.Va.
12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Otha Coleman		14. MOTHER'S MAIDEN NAME Rebecca Duckworth	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	17. INFORMANT Address
no		no	Mrs. Mary E. Coleman-Westernport, Md.
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>chronic Myositis and Myocardial Degeneration</i> <i>specified as Rheumatic</i>		INTERVAL BETWEEN ONSET AND DEATH 100 Years	
415X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <i>Diabetes Mellitus</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED White Not while at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>Aug 5, 1956</i> to <i>Sept 3, 1956</i> that I last saw the deceased alive on <i>Sept. 2, 1956</i> , and that death occurred at <i>3:40 AM</i> , from the causes and on the date stated above. ACTUAL SIGNATURE <i>Paul B. Wilson</i> ADDRESS (Street, city or town, state) <i>Piedmont, W.Va.</i> DATE SIGNED <i>9-5-56</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Sept 5, 56	22c. NAME OF CEMETERY OR CREMATORIAL Philos
22d. LOCATION (City, town, or county) Westernport		(State) Md.	
23. FUNERAL DIRECTOR'S SIGNATURE <i>El Boal</i>		ADDRESS Westernport, Md.	24a. REC'D BY REGISTRAR DATE <i>9-5-56</i>
		24b. REGISTRAR'S SIGNATURE <i>Jean C Kelly</i>	

CERTIFICATE OF DEATH

MARYLAND

BALTIMORE CITY

BUREAU V. S.

SEP 10 1956

REGELIVE

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death: Page 4  
 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to a burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Within Corporate Limits  
8871

08868

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH a. COUNTY <b>Allegany</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>		c. LENGTH OF STAY IN lb <b>8/2/56</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Allegany County Infirmary</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>108 Maple Street, Frostburg, Md.</b>	
3. NAME OF DECEASED (Type or print) <b>Anna</b>		First <b>Isabelle</b>	Middle <b>College</b>
4. DATE OF DEATH <b>September 28, 1956</b>		Month <b>September</b>	Day <b>28</b>
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <b>4/12/1875</b>		9. AGE (in years day birthday) <b>81</b>	IF UNDER 1 YEAR Months <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	11. BIRTHPLACE (State or foreign country) <b>Clearfield, Pennsylvania</b>
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>			
13. FATHER'S NAME <b>Joseph Wilkins</b>		14. MOTHER'S MAIDEN NAME <b>Jane Reed</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	17. INFORMANT <b>Allegany County Infirmary Records</b>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).]  PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)  <i>420.1</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.  (b) DUE TO  (c)		INTERVAL BETWEEN ONSET AND DEATH  <i>Coronary Thrombosis</i> ,  <i>Sudden</i> .  <i>Chronic Myocarditis</i> ,  <i>?</i>  <i>General Arteriosclerosis</i> ,  <i>?</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)  <i>Chronic nephritis</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>8/2/56</b> , 19_____, to <b>9/28/56</b> , 19_____, that I last saw the deceased alive on <b>9/28/56</b> , 19_____, and that death occurred at <b>11:15 AM</b> , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <b>M.D. 149 Greene St, Cumberland, Md.</b>	
ACTUAL SIGNATURE <i>James E. McLean</i>		DATE SIGNED <b>9/28/56</b>	
PHYSICIAN'S NAME (Type) <b>Dr. James E. McLean</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>10/1/56</b>	22c. NAME OF CEMETERY OR CREMATORIAL ADDRESS <b>Frostburg Memorial Park Frostburg</b>
22d. LOCATION (City, town, or county) <b>Md.</b>		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Bethel N. Winter</i>		24a. REC'D BY REGISTRAR <b>Oct 3, 1956</b>	24b. REGISTRAR'S SIGNATURE <i>Winter R. Jones, Jr.</i>
		DATE	

RECEIVED  
BUREAU OF INVESTIGATION  
U.S. DEPARTMENT OF JUSTICE  
OCT 5 1956

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08869

Reg. Dist. No.

8872

## CERTIFICATE OF DEATH

Within corporate limits

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)	
Allegany MARYLAND		a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland	c. LENGTH OF STAY IN 1b 54 yrs.	b. COUNTY Allegany	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Dead On arrival-Memorial Hospital		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland	
3. NAME OF DECEASED (Type or print)		First Cora	Middle Norris
		Last Compton	4. DATE OF DEATH Sept. 13
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> b. DATE OF BIRTH WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> April 8, 1874	8. AGE (In years last birthday) 82 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	9. IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS.
10c. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Frank W. Norris		14. MOTHER'S MAIDEN NAME Anna Hoover	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. none	
17. INFORMANT		Address Miss Lillian Compton, Cumberland, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO Arterio sclerosis - (c)		INTERVAL BETWEEN ONSET AND DEATH 9-19.56	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month. Day. Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED White Nat white at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 9-19, 1956 to 9-19, 1956 that I last saw the deceased alive on 9-19, 1956, and that death occurred at 530 AM, from the causes and on the date stated above. ACTUAL SIGNATURE F. W. Eliason PHYSICIAN'S NAME (Type)		ADDRESS (Street, city or town, state) F. W. Eliason - 126 Union St. Cumberland Md. DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8-22-56	
22c. NAME OF CEMETERY OR CREMATORIAL Mt. Olivet		22d. LOCATION (City, town, or county) Frederick, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE James F. Scarcelli, Cumberland, Md.		24a. RECEIVED BY REGISTRAR DATE 8-21-1956	
		24b. REGISTRAR'S SIGNATURE W.R. Frank, M.D.	

WISCONSIN STATE DEPARTMENT OF HEDGIN-BALTIMORE, I.D.

CERTIFICATE OF DEATH

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BUREAU V. S.

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SEP 24 1962

Within corporate limits

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8873

## CERTIFICATE OF DEATH

08870 4

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Allegany</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>		c. LENGTH OF STAY IN 1b <b>13 days</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SACRED HEART HOSPITAL</b>		e. STREET ADDRESS <b>114 Winton Place</b>		
3. NAME OF DECEASED (Type or print) <b>Homer</b>		First <b>H</b>	Middle <b>Cooper</b>	
4. DATE OF DEATH <b>September 13 19 56</b>	Month <b>Sept.</b>	Day <b>13</b>	Year <b>1956</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	B. DATE OF BIRTH <b>Aug. 7, 1901</b>	
8. AGE (In years last birthday) <b>55 yrs.</b>	9. IF UNDER 1 YEAR <b>Months</b>	10. IF UNDER 24 HRS. <b>Days</b>	11. HOURS <b>Hours</b>	12. MINUTES <b>Min.</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Brewery</b>		11. BIRTHPLACE (State or foreign country) <b>West Virginia</b>
13. FATHER'S NAME <b>George W. Cooper</b>		14. MOTHER'S MAIDEN NAME <b>Elizabeth Harriet Harper</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No,</b>		16. SOCIAL SECURITY NO. <b>219-03-9022</b>		17. INFORMANT <b>Mrs. Elizabeth Cooper 114 Winton Place, Cumb. Md.</b>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac-renal failure</b>		INTERVAL BETWEEN ONSET AND DEATH <b>12 mos</b>		
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>527.1</b>				
(b) <b>Cor pulmonale</b>		18 mos		
DUE TO (c) <b>Emphysema</b>		5 years		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>12-21 1955</b> , to <b>9-13 1956</b> , that I last saw the deceased alive on <b>9-13 1956</b> , and that death occurred at <b>1:00 p.m.</b> from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED		
ACTUAL SIGNATURE <b>R.W. Ballin.</b>		M.D.		
PHYSICIAN'S NAME (Type) <b>R.W. Ballin, M.D.</b>		62 Greene St.		Cumberland, Md. 9-14-56
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>9/15/56</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Harper Cemetery</b>
22d. LOCATION (City, town, or county) <b>Harman, W. Virginia</b>		(State)		
23. FUNERAL DIRECTOR'S SIGNATURE <b>H. Wayne George</b>		ADDRESS <b>Cumberland, Md.</b>		24a. REC'D BY REGISTRAR <b>Sept. 15, 1956</b>
				24b. REGISTRAR'S SIGNATURE <b>W.R. Frank, M.D.</b>

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BUREAU V. S

SEP 18 1956

RECEIVED

Within corporate limits

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

108871

8874

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Allegany</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Allegany</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>		c. LENGTH OF STAY IN 1b <b>2 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>		d. STREET ADDRESS <b>627 Elwood Street</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Sacred Heart Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <b>Nancy Ann Coyle</b>		First	Middle	Last	4. DATE OF DEATH <b>September 11 1956</b>	Month	Day	Year
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	B. DATE OF BIRTH <b>September 9, 56</b>	9. AGE (In years last birthday) yrs. <b>2</b>	IF UNDER 1 YEAR Months <b>2</b>	IF UNDER 24 HRS. Days <b>11</b>	Hours <b>56</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (State or foreign country) <b>Cumberland, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>James E. Coyle</b>		14. MOTHER'S MAIDEN NAME <b>Mary M. Kilduff</b>				Address <b>Cumberland, Md 627 Elwood St.,</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Patients chart &amp; James E. Coyle</b>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac Failure</b> 770.0		DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. <b>Congenital Heart Disease</b>		INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b>				
DUE TO <b>Erythroblastosis Fetalis</b>				3 days				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>Cumberland</b>		(County) <b>Maryland</b>
21. I certify that I attended the deceased from _____, 19_____, to _____, 19_____, that I last saw the deceased alive on _____, 19_____, and that death occurred at <b>10:35 PM</b> , from the causes and on the date stated above.				ADDRESS (Street, city or town, state) <b>63 Green St., Cumberland MD 1956</b>		DATE SIGNED <b>Sept 12 1956</b>		
ACTUAL SIGNATURE <b>L. B. Ransom</b>		M.D.						
PHYSICIAN'S NAME (Type) <b>L. B. Ransom, M.D.</b>								
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>9/12/56</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>St. Mary's Cemetery</b>		22d. LOCATION (City, town, or county) <b>Cumberland, Maryland</b>		(State)
23. FUNERAL DIRECTOR'S SIGNATURE <b>H. Wayne George</b>		ADDRESS <b>Cumberland, Maryland</b>		24a. REC'D BY REGISTRAR <b>Sept 12, 1956</b>		24b. REGISTRAR'S SIGNATURE <b>W.R. Gratz, M.D.</b>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

UNIVERSITY OF CALIFORNIA - LOS ANGELES  
CITY COLLEGE OF LOS ANGELES

BUREAU V.

SEP 17 1956

RECEIVED

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 8931 CERTIFICATE OF DEATH

108872  
9

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Allegany</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Allegany</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frostburg</b>		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frostburg, Rural Route # 1</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Miners Hospital</b>		d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <b>William</b>	Middle 	Last <b>Cutter</b>	4. DATE OF DEATH <b>9/28/1956</b>	Month 9	Day 28	Year 1956
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5/20/1871</b>	9. AGE (In years lost birthday) <b>85 yrs.</b>	IF UNDER 1 YEAR Months 	IF UNDER 24 HRS. Days 	Hours 
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Miner</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Coal Mine</b>		11. BIRTHPLACE (State or foreign country) <b>Lonaconing, MD.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Frederick Cutter</b>				14. MOTHER'S MAIDEN NAME <b>Ellen Humberson</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO.		17. INFORMANT		Address <b>Clinton Cutter, Frostburg, Md. R.F.D.1</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic Heart Disease</b> INTERVAL BETWEEN ONSET AND DEATH <b>Years</b> 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Congestive Heart Failure</b> Months DUE TO (c) <b>Pneumonia &amp; Cerebral</b> Months							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>8</b> , 19 <b>56</b> , to <b>9/28</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>9/27</b> , 19 <b>56</b> , and that death occurred at <b>2 AM</b> , from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) <b>134 E Main Frostburg, Md.</b> DATE SIGNED <b>9/28/56</b>							
ACTUAL SIGNATURE <b>John C. Davis</b>		PHYSICIAN'S NAME (Type) <b>John C. Davis</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>10/1/1956</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Cutter Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Klondyke, MD.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>GEORGE EICHORN, Lonaconing, MD.</b>				ADDRESS 24a. REC'D BY REGISTRAR DATE <b>10-1-56</b> 24b. REGISTRAR'S SIGNATURE <b>Doris Nancy N. Rose</b>			

BUREAU V. 2

OCT 9 1956

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08873

DR. R.J. WILLIAMS

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death; Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH o. COUNTY ALLEGANY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 92 CUMBERLAND		c. LENGTH OF STAY IN 1b 4 DAYS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First DELORES Middle ANN Last DIEHL		4. DATE OF DEATH Month SEPTEMBER Day 12 Year 1956	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH OCTOBER 13, 1935
			9. AGE (In years last birthday) 20 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) CUMBERLAND, MD.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME BENJAMIN ORT		14. MOTHER'S MAIDEN NAME CORA ROBERTSON	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? [Yes, no, or unknown] 10		16. SOCIAL SECURITY NO. 220-32-4857	
		17. INFORMANT MEMORIAL HOSPITAL - CUMBERLAND, MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 260X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) Lipemia complicating (c) Diabetes Mellitus.		90 hrs	
DUE TO			
DUE TO			
DUE TO			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 9/18/56, 19, to 9/18/56, 19, that I last saw the deceased alive on 9/18/56, 19, and that death occurred at 10:50 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE DR. R.J. WILLIAMS		ADDRESS (Street, city or town, state) CUMBERLAND, MD. DATE SIGNED 2/17/56	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Sept 18/56	
22c. NAME OF CEMETERY OR CREMATORIAL METH. CEM.		22d. LOCATION (City, town, or county) MT. SAVAGE MD. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Louis Stein Inc. Cumb. Md.		24a. REC'D BY REGISTRAR DATE 9/14/1956	
		24b. REGISTRAR'S SIGNATURE J. L. Frank, M.D.	

DEPARTMENT OF HOMELAND SECURITY  
FEDERAL BUREAU OF INVESTIGATION  
CERTIFICATE OF DEATH

DEATH CERTIFICATE NO. 0300020

NAME: MURKIN, ROBERT L.  
ADDRESS: 1010 14TH ST., N.W., WASHINGTON, D.C.  
AGE: 30  
SEX: MALE  
MATERIAL TESTED: BLOOD

CAUSE OF DEATH: SUICIDE

FEDERAL BUREAU OF INVESTIGATION

SEP 18 1956

RECEIVED

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08874

8944

## CERTIFICATE OF DEATH

Reg. Dist. No. 10.

1. PLACE OF DEATH a. COUNTY <b>Allegany</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b>		b. COUNTY <b>Allegany</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mt. Savage</b>		c. LENGTH OF STAY IN lb <b>31 yrs.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mt. Savage</b>		d. STREET ADDRESS <b>R.D. #1, Wellersburg Rd</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Old Row</b>				d. STREET ADDRESS <b>R.D. #1, Wellersburg Rd</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Lulu</b>		First <b>A.</b>	Middle <b>Diehl</b>	4. DATE OF DEATH Last <b>9 15 19 56</b>	Month <b>9</b>	Day <b>15</b>	Year <b>19 56</b>
S. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH <b>3 - 10 - 1889</b>	9. AGE (In years lost birthday) <b>67 yrs.</b>	IF UNDER 1 YEAR Months <b>67</b>	IF UNDER 24 HRS. Days <b>0</b>	Hours <b>0</b>
F. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housework</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (State or foreign country) <b>Eckhart, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Peter Paul Michael</b>				14. MOTHER'S MAIDEN NAME <b>Margaret Martin</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Mrs. Michael E. Flanigan, Mt. Savage, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <b>170X</b> <b>PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic carcinoma to lungs, abdominal organs.</u> INTERVAL BETWEEN ONSET AND DEATH <b>8 months</b></b>							
Conditions, if any, which gove rise to immediate cause (a), stating the under- lying cause last.		(b) <b>Carcinoma, right breast.</b>				<b>8 years</b>	
(c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Dec. 9, 1955</b> , to <b>Sept. 14, 1956</b> , that I last saw the deceased alive on <b>Sept. 14, 1956</b> , and that death occurred at <b>8:00 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Thomas F. Lewis, M.D. 5 Washington Street</b> DATE SIGNED <b>Thomas F. Lewis, M.D. 5 Washington Street</b>							
ACTUAL SIGNATURE <b>Thomas F. Lewis, M.D.</b>		PHYSICIAN'S NAME (Type) <b>Thomas F. Lewis, M.D.</b> CUMBERLAND, ALLEGANY COUNTY, MARYLAND					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>9-18-56</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>St. Patrick's Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Mt. Savage, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>B.H. Monticourt</b>		ADDRESS <b>Hafer Funeral Home 23 E. Main, Frostburg, Md.</b>		24a. RECD BY REGISTRAR <b>Veronica M. Dermott</b>		24b. REGISTRAR'S SIGNATURE <b>Veronica M. Dermott</b>	
VS A15 (4) 1SM 9/55				DATE <b>9/20/56</b>			

BUREAU V.

SEP 24 1956

**RECEIVED**

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08875

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Within corporate limits

8876

Reg. Dist. No.

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending", in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director, age 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

D.O.A.

1. PLACE OF DEATH a. COUNTY <b>Allegany</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>W.Va.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>		c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Ridgely</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>at the Sacred Heart Hospital</b>		d. STREET ADDRESS <b>14 Perry St.</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <b>James</b>	Middle <b>Paul</b>	Last <b>Dittmer Jr.</b>
4. DATE OF DEATH	Month <b>Sept.</b>	Day <b>30</b>	Year <b>1956</b>
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 22-1924</b>
9. AGE (in years last birthday) <b>32 yrs.</b>	10. IF UNDER 1 YEAR Months <b>0</b>	11. IF UNDER 24 HRS. Days <b>0</b>	12. IF UNDER 24 HRS. Hours <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Metal worker</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Fairchild</b>	11. BIRTHPLACE (State or foreign country) <b>Hagerstown, Md.</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>James Paul Dittmer, Sr.</b>	14. MOTHER'S MAIDEN NAME <b>Villa Grace</b>	15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Yes-Navy W.W. 2</b>	
16. SOCIAL SECURITY NO. <b>219-14-5171</b>	17. INFORMANT <b>(father) Jas. P. Dittmer, Ridgely, W.Va.</b>	Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary occlusion</b>			
INTERVAL BETWEEN ONSET AND DEATH <b>sudden</b>			
PART II. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary occlusion</b>			
DUE TO Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Coronary sclerosis</b>			
DUE TO (c)			
? <b>?</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> *, and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <i>H. V. Deming M.D.</i>	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED
EXAMINER'S NAME (Type) <b>H. V. Deming M.D.</b>	ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		<b>Sept. 30-1956</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>10/3/56</b>	22c. NAME OF CEMETERY OR CREMATORIAL <b>Hillcrest Burial Pk.</b>	22d. LOCATION (City, town, or county) (State) <b>Cumberland, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <i>H. Wayne George</i>	ADDRESS <b>Cumberland, Md.</b>	24a. REC'D BY REGISTRAR DATE <b>Oct. 2, 1956</b>	24b. REGISTRAR'S SIGNATURE <i>J. R. Brant, M.D.</i>

BUREAU V. S.

OCT 3 1956

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

108876

8945

## CERTIFICATE OF DEATH

Reg. Dist. No. 6

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Md. b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Barton		c. LENGTH OF STAY IN 1b 10 Yrs	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Temperance St.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Barton	
3. NAME OF DECEASED (Type or print) Oliver First Cass Middle Fazenbaker		4. DATE OF DEATH Sept Month 6 Day Year 1956	
S. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept 14, 1880
9. AGE (In years lost birthday) 75 yrs.		10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Own Farm	
10c. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Marcus Fazenbaker		14. MOTHER'S MAIDEN NAME Ellen Broadwater	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 17. INFORMANT Address Mrs. O.C. Fazenbaker-Westernport, Barton, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <i>Hypertensive cardiovascular disease with congestive heart failure</i>		INTERVAL BETWEEN ONSET AND DEATH 3 years	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i> </i> DUE TO (c) <i> </i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m. <i> </i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>Jan 6</i> , 1953, to <i>Sept 6</i> , 1956, that I last saw the deceased alive on <i>Sept 6</i> , 1956, and that death occurred at <i>4 PM</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>James McWhorter Jr.</i>		ADDRESS (Street, city or town, state) <i>Piedmont W. Va</i> DATE SIGNED <i>9-7-56</i>	
PHYSICIAN'S NAME (Type)		22d. LOCATION (City, town, or county) (State) <i>Westernport Md.</i>	
22e. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22f. DATE THEREOF <i>9/8/56</i>	
22g. NAME OF CEMETERY OR CREMATORIALy <i>Philos Cem</i>		24a. REC'D BY REGISTRAR DATE <i>9-9-56</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>E. J. Bon</i>		24b. REGISTRAR'S SIGNATURE <i>George Kelly</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

SEP 13 1956

**RECEIVE**

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending", in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial/transit permit. File pages 1 and 2 with the registrar prior to burial, cremation or removal.

1  
Outside of  
City limits  
PLATE DEATH  
o. COUNTY

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08877

Reg. Dist. No. 4

8945

Allegany

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

c. LENGTH OF STAY IN lb

Rural) Cumberland

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

B&O.R.Ry. near North Branch, Md.

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)

a. STATE

b. COUNTY

Md.

Allegany

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Cumberland

d. STREET ADDRESS

224 Harrison St.

e. IS RESIDENCE ON A FARM?

YES  NO

3. NAME OF  
DECEASED  
(Type or print)

First  
Middle

Last

4. DATE  
OF  
DEATH

Month

Day

Year

5. SEX

6. COLOR OR RACE

7. MARRIED  NEVER MARRIED

8. DATE OF BIRTH

9. AGE (In years  
last birthday)

23  
yrs.

IF UNDER 1 YEAR

IF UNDER 24 HRS.

Months

Days

Hours

Min.

male

white

WIDOWED  DIVORCED

Feb. 3-1933

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF WHAT COUNTRY?

Sheet Metal Mechanic-Pitts. P & G. Co

Cumberland, Md.

U.S.A.

13. FATHER'S NAME

Walter F. Files

14. MOTHER'S MAIDEN NAME

Ida Shears

15. WAS DECEASED EVER IN THE ARMED FORCES? (Yes, no, or unknown)

(If yes, give rank or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

Address

yes

w.w.2

220-28-7625 (wife) Lois Files, Cumberland, Md.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY  
IMMEDIATE CAUSE (a)

Intracranial hemorrhage due to a crushed  
skull, fractures of all extremities, ribs,  
right clavicle & pelvis.

INTERVAL BETWEEN  
ONSET AND DEATH

sudden

Conditions, if any, which  
gave rise to immediate cause  
(a), stating the underlying  
cause lost.

(b)  
DUE TO  
(c)

In auto at B&O R.Ry. North Branch Crossing.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED?

YES  NO

20a. EXTERNAL CAUSE WAS  
PRIMARY  OR CONTRIBUTING   
CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

Auto stalled on reverse & hit by a B&O diesel engine.

20c. TIME OF INJURY

Month, Day, Year

20d. INJURY OCCURRED

20e. PLACE WHERE INJURED

20f. (City or town)

(County)

(State)

Hour

o. m.

7.15 Sept 24 1956

p. m.

While  
at work  Not while  
of work

Not while  
of work

B&O R.Ry. Crossing

Cumberland, Allegany, Md.

21. I certify that I took charge of the remains described above, held an Autopsy , Inspection , Inquiry , and find that death resulted from: Natural causes , Accident , Suicide , Homicide , Undetermined cause .

ACTUAL  
SIGNATURE

EXAMINER'S  
NAME (Type)

H. V. Deming M.D.

M.D. CHIEF MEDICAL EXAMINER

ASSISTANT MEDICAL EXAMINER

DEPUTY MEDICAL EXAMINER

DATE SIGNED

Sept. 24-1956

22a. BURIAL, CREMATION, REMOVAL (Specify)

Davis Memorial Sept. 26,

22c. NAME OF CEMETERY OR CREMATORIUM

1956 Davis Memorial

22d. LOCATION (City, town, or county)

Cumberland,

(State)

Maryland

23. FUNERAL DIRECTOR'S SIGNATURE

James F. Scarpell

ADDRESS

Cumberland, Maryland

24a. REC'D BY REGISTRAR

DATE

Sept. 26, 1956

W. R. Tracy, M.D.

BUREAU Y

DP 08 1956

RECEIVED

## Within corporate limits MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8877

DR. TOPPER

## CERTIFICATE OF DEATH

08878

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY ALLEGANY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE PENNSYLVANIA b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 23 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HYNDMAN 75X-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL-MEMORIAL AVE.		d. STREET ADDRESS RT. #1		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First MELVILLE Middle M Last FOST		4. DATE OF DEATH Month SEPTEMBER 26 Day Year 1956			
5. SEX MALE WHITE		6. COLOR OR RACE WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> B. DATE OF BIRTH FEB. 29	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Factory wkr.		10b. KIND OF BUSINESS OR INDUSTRY Celanese		11. BIRTHPLACE (State or foreign country) PA.	
13. FATHER'S NAME HENRY FOST		14. MOTHER'S MAIDEN NAME MARGARET SALYARDS		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 217-10-5338		17. INFORMANT Address MEMORIAL HOSPITAL-CUMBERLAND, MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]  PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Canceroma Left Lung		INTERVAL BETWEEN ONSET AND DEATH 6 months	
DUE TO  Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 1, 1956, to Sep 26, 1956, that I last saw the deceased alive on Sep 26, 1956, and that death occurred at Hyndman, Pa., from the causes and on the date stated above.				ADDRESS (Street, city or town, State) Hyndman, Pa.	
ACTUAL SIGNATURE John A. Topper M.D.				DATE SIGNED 9-27-56	
PHYSICIAN'S NAME (Type) John A. Topper					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-30-56		22c. NAME OF CEMETERY OR CREMATORIAL Palo Alto Cemetery	
22d. LOCATION (City, town, or county) Hyndman, Pa.					
23. FUNERAL DIRECTOR'S SIGNATURE Harvey Zeigler		ADDRESS Hyndman, Pa.		24a. REC'D BY REGISTRAR DATE Sept 28, 1956	
				24b. REGISTRAR'S SIGNATURE W. R. Drury, M.D.	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/55

**RECEIVED**

OCT 1 1956

**BUREAU V. S.**

Within corporate limits

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08878

8878

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pogg 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>WEST VIRGINIA</b>		b. COUNTY <b>HAMPSHIRE</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>		c. LENGTH OF STAY IN 1b <b>4 DAYS</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ROMNEY</b>		d. STREET ADDRESS	
d. NAME OF HOSPITAL (If deceased in hospital, give name and address) OR INSTITUTION <b>MEMORIAL HOSPITAL</b> <b>MEMORIAL &amp; WARWICK AVES</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <b>WILLIAM</b>	Middle <b>LEE</b>	Last <b>FULLER</b>	4. DATE OF DEATH	Month <b>SEPTEMBER</b>	Day <b>19</b>	Year <b>1956</b>
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH <b>SEPTEMBER 15, 1956</b>	9. AGE (In years from birthday) yrs. <b>3</b>	IF UNDER 1 YEAR Months <b>3</b>	IF UNDER 24 HRS. Days <b>16</b>	Hours <b>29</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>CUMBERLAND, MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>REN FULLER JR.</b>				14. MOTHER'S MAIDEN NAME <b>FAE A. LONG</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>	16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Memorial Hospital</b>	Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>770.5</b>				INTERVAL BETWEEN ONSET AND DEATH <b>4 days</b>			
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) DUE TO							
DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. p. m.	Month 19	Day	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Ebenezer</b>	20f. (City or town) <b>Romney</b>	(County)	(State) <b>W. Va.</b>
21. I certify that I attended the deceased from <b>9/15</b> , 1956, to <b>9/19</b> , 1956, that I last saw the deceased alive on <b>9/18</b> , 1956, and that death occurred at <b>Romney</b> , W. Va., from the causes and on the date stated above. ACTUAL SIGNATURE <b>W. R. Hodges</b>				ADDRESS (Street, city or town, state) <b>Ebenezer, W. Va.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		22b. DATE THEREOF <b>Sept 22, 1956</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Ebenezer</b>		22d. LOCATION (City, town, or county) <b>Romney</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Keith Shaffer</b>		ADDRESS <b>Romney</b>		24e. REC'D BY REGISTRAR <b>Sept. 22, 1956</b>		24f. REGISTRAR'S SIGNATURE <b>Ed. R. Frank, M. D.</b>	
VS A15 (4) 1SM 9/55							
2060232XV3							

DEPARTMENT OF DEFENSE  
COMMITTEE ON DEATH

1956 MARCH 12

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BUREAU Y.

SEP 26 1956

REGELIVE

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8947

## CERTIFICATE OF DEATH

08880

Reg. Dist. No.

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH o. COUNTY <b>Allegany</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) o. STATE <b>Maryland</b>		b. COUNTY <b>Allegany</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Lonaconing</b>		c. LENGTH OF STAY IN 1b <b>84 yrs.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Lonaconing</b>				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Washington Street</b>		d. STREET ADDRESS <b>Washington Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)	First <b>SARAH</b>	Middle <b>JANE</b>	Last <b>GARDNER</b>	4. DATE OF DEATH <b>9/26/1956</b>	Month <b>9</b>	Day <b>26</b>	Year <b>19</b>	
S. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH <b>Feb. 22. 1872</b>	9. AGE (In years lost birthday) <b>84 yrs.</b>	IF UNDER 1 YEAR Months <b>0</b>	IF UNDER 24 HRS. Days <b>0</b>	Hours <b>0</b>	Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housework</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (State or foreign country) <b>Lonaconing, MD.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>William G. Gardner</b>		14. MOTHER'S MAIDEN NAME <b>Eliza Bradley</b>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>NONE</b>		17. INFORMANT <b>Mrs. Robert Matthews, Lonaconing, MD.</b>		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral vascular accident</b>				(Daughter)		INTERVAL BETWEEN ONSET AND DEATH <b>24 hrs.</b>		
1443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>Essential hypertension</b>						years		
DUE TO <b>Congestive Heart failure</b>						years		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour o. m. p. m.	Month 19	Day	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)	
21. I certify that I attended the deceased from <b>July 1</b> , 1956, to <b>Sept. 26</b> , 1956, that I last saw the deceased alive on <b>Sept. 25</b> , 1956, and that death occurred at <b># a. M.</b> from the causes and on the date stated above.				ADDRESS (Street, city or town, state)			DATE SIGNED	
ACTUAL SIGNATURE <b>Leslie R. Miles, Jr.</b>		M.D.						
PHYSICIAN'S NAME (Type)		<b>Leslie R. Miles, Jr., M.D.</b>						
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>9/28/1956</b>	22c. NAME OF CEMETERY OR CREMATORIUM <b>Oak Hill Cemetery</b>		22d. LOCATION (City, town, or county) <b>Lonaconing, MD.</b>		(State)		
23. FUNERAL DIRECTOR'S SIGNATURE <b>George Eichhorn, Lonaconing, MD.</b>		ADDRESS		24a. REC'D BY REGISTRAR DATE <b>10-1-56</b>		24b. REGISTRAR'S SIGNATURE <b>Jeanette M. Boal</b>		

BUREAU V. A.  
RECEIVED

OCT 5 1956

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

08881

## 8879 CERTIFICATE OF DEATH

Reg. Dist. No. 4

## INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

<b>1. PLACE OF DEATH</b>		<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>	
COUNTY CITY (If outside corporate limits, write RURAL OR TOWN Cumberland	MARYLAND LENGTH OF STAY (in this place) 9/15/56	STATE Maryland	COUNTY Maryland Allegany
HOSPITAL OR INSTITUTION OR STREET ADDRESS Allegany County Infirmary		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland	STREET ADDRESS (If rural give location) 714 St. Mary's Avenue

<b>3. NAME OF DECEASED (Type or Print)</b>		<b>(First)</b> Virgil	<b>(Middle)</b> L.	<b>(Last)</b> Gehauf	<b>4. DATE OF DEATH</b> September 16, 56
S. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widower	8. DATE OF BIRTH 6/7/1885	9. AGE last birthday 71 yrs.	IF UNDER 1 YEAR Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired - City Employee	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? U. S. A.
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13. FATHER'S NAME Henry Gehauf	14. MOTHER'S MAIDEN NAME Mary Davis
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) No	16. SOCIAL SECURITY NO. None	17. INFORMANT & ADDRESS Allegany County Infirmary Records
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<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>		<b>18. MEDICAL CERTIFICATION</b>	<b>INTERVAL BETWEEN ONSET AND DEATH</b>
422.2 IMMEDIATE CAUSE ANTECEDENT CAUSE(S) DUE TO	(A)	Pulmonary Eosinophilia	?
DISEASES OR CONDITIONS, IF ANY, (B) GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.	(C)	Chronic Myocarditis	?
		Cerebral Arteriosclerosis	?
		Bronchogenic Carcinoma	?

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED M. at work <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 9/15/56, 19....., to 9/16/56, 19....., that I last saw the deceased alive on 9/16/56, 19....., and that death occurred at 10:45A, from the causes and on the date stated above.			
SIGNATURE Dr. James E. McLean		ADDRESS (Street, city, town, state) M.D. 49 Greene St., Cumberland, Md.	DATE SIGNED 9/17/56
23. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	DATE THEREOF Sept. 18-1956	NAME OF CEMETERY OR CREMATORIUM Rose Hill Cemetery	LOCATION (City, town, or county) CUMBERLAND

24. REC'D BY REGISTRAR DATE Sept. 18, 1956	REGISTRAR'S SIGNATURE Winter R. Frantz, M.A.	25. FUNERAL DIRECTOR'S SIGNATURE Louis Stein, Inc. Cumberland, Md.
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UNITED STATES GOVERNMENT - STATE DEPARTMENT

CERTIFICATE OF DATA

10 SEP 1956

ALL INFORMATION CONTAINED

HEREIN IS UNCLASSIFIED  
DATE 10 SEP 1956 BY [redacted]

ALL INFORMATION CONTAINED

HEREIN IS UNCLASSIFIED

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DATE 10 SEP 1956 BY [redacted]

ALL INFORMATION CONTAINED

BUREAU U.S.

SEP 20 1956

RECEIVED  
FBI - NEW YORK

1  
Walsh corporate limits

# MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

08882

8880

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

M

### INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death.  
**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10W

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY Allegany CITY (If outside corporate limits, write RURAL OR end give nearest town) TOWN Cumberland		MARYLAND LENGTH OF STAY (In this place) 17 da.	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Sylvan Retreat, Furnace St.		STATE Maryland CITY (If outside corporate limits, write RURAL and give nearest town) TOWN NEAR Cumberland, RURAL STREET ADDRESS (If rural give location) R.F.D. No. 1, La Vale	
3. NAME OF DECEASED (Type or Print) Dorothy		4. DATE (Month) (Day) (Year) Sept. 20 1956	
5. SEX F.	6. COLOR OR RACE W.	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Single	8. DATE OF BIRTH May 16, 1902
9. AGE last birthday 57 yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none	11. BIRTHPLACE (State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Bradford Gibbs	14. MOTHER'S MAIDEN NAME Cora E. Smith		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) No	16. SOCIAL SECURITY NO. None	17. INFORMANT & ADDRESS Robert Gibbs Va. Ave. Cumberland Md.	18. MEDICAL CERTIFICATION INTERVAL BETWEEN ONSET AND DEATH Sudden
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 420.1 IMMEDIATE CAUSE (A) ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, (B) GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)		Secondary Thrombosis. Chronic Myocarditis. Secondary Anemia Mental deficiency Hereditary defect life	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		?	
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>Aug. 22, 1952</u> , to <u>Sept. 20, 1956</u> , that I last saw the deceased alive on <u>Sept. 19, 1956</u> , and that death occurred at <u>8:50 A.M.</u> from the causes and on the date stated above. SIGNATURE <u>George E. Chean</u> M.D. ADDRESS <u>49 Trellis St.</u> DATE SIGNED <u>9-20-56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	DATE THEREOF Sept. 22, 1956	NAME OF CEMETERY OR CREMATORIAL Rose Hill Cemetery	LOCATION (City, town, or county) Cumberland, Maryland. (State)
24. REC'D BY REGISTRAR <u>John R. Frank Jr.</u>	REGISTRAR'S SIGNATURE <u>Winter R. Frank Jr.</u>	25. FUNERAL DIRECTOR'S SIGNATURE Wayne George, Cumberland, Maryland.	ADDRESS
DATE <u>Sept. 21, 1956</u>			

THE FEDERAL BUREAU OF INVESTIGATION  
U.S. DEPARTMENT OF JUSTICE

EXHIBIT TO DEATH

25

202

BUREAU U. S.

SEP 24 1956

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**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death: Page 4  
 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Within corporate limits  
8881

108883

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH a. COUNTY <b>Allegany</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>		c. LENGTH OF STAY IN 1b <b>2/11/56</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Allegany County Infirmary</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <b>Idella</b>	Middle <b>M.</b>	Last <b>Glover</b>		
4. DATE OF DEATH <b>September 30,</b>	Month <b>19</b>	Day <b>56</b>	Year		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3/24/1905</b>		
9. AGE (In years last birthday) <b>51</b>	10. IF UNDER 1 YEAR Months <b>5</b>	11. IF UNDER 24 HRS. Days <b>9</b>	12. yrs. Hours <b>10</b>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>	10b. KIND OF BUSINESS OR INDUSTRY <i>Own Home</i>	11. BIRTHPLACE (State or foreign country) <b>West Virginia</b>	12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		
13. FATHER'S NAME <b>Daniel Hawse</b>	14. MOTHER'S MAIDEN NAME <b>Elizabeth Loy</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>	16. SOCIAL SECURITY NO. <b>None</b>	17. INFORMANT	Address <b>599 - P.O.Box</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>170X</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) DUE TO DUE TO DUE TO			INTERVAL BETWEEN ONSET AND DEATH <i>12 mos</i>		
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>conscious - conscious of breast</i>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Hour a. p.m. 19	Month a. p.m. 19	Day Not while at work <input type="checkbox"/> at work <input type="checkbox"/>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>2/11/56</b> , 19, to <b>9/30/56</b> , 19, that I last saw the deceased alive on <b>9/30/56</b> , 19, and that death occurred at <b>9:45 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>49 Greene St.</b> DATE SIGNED <b>10/1/56</b>					
ACTUAL SIGNATURE <i>R. L. Mathews</i>	M.D.				
PHYSICIAN'S NAME (Type) <b>Dr. L. B. Mathews</b>	<b>Cumberland, Md.</b>				
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>10-2-1956</b>	22c. NAME OF CEMETERY OR CREMATORIUM <b>Hill Crest Cemetery</b>	22d. LOCATION (City, town, or county) <b>Cumberland, Maryland</b>	(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>William H. Kight, Cumberland, Maryland</b>	ADDRESS <b>Oct. 1, 1956</b>	24a. REC'D BY REGISTRAR <b>W. R. Tracy, M.D.</b>	24b. REGISTRAR'S SIGNATURE		

**RECEIVED**

OCT 3 1956

**BUREAU V. S.**

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with farm PM3. Page 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1 Within corporate limits MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
888 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08884

Reg. Dist. No. 4

1. PLACE OF DEATH a. COUNTY <b>Allegany</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>W.Va.</b>		b. COUNTY								
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>		c. LENGTH OF STAY IN 1b <b>5 hrs.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Piedmont</b>		d. STREET ADDRESS <b>1 East Harrison St.</b>								
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Memorial Hospital</b>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
3. NAME OF DECEASED (Type or print) <b>Katherine Virginia Greenhorn (Collett)</b>		First	Middle	Last	4. DATE OF DEATH <b>Sept. 24</b>	Month	Day	Year						
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH <b>May 15-1917</b>	9. AGE (In years last birthday) <b>39 yrs.</b>	IF UNDER 1YEAR Months	IF UNDER 24 HRS. Days	Hours	Min.						
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Piedmont, W.Va.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>								
13. FATHER'S NAME <b>William Greenhorn</b>				14. MOTHER'S MAIDEN NAME <b>Daisy Alderton</b>										
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO.		17. INFORMANT (father) William Greenhorn,		Address								
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]  PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <b>Subdural hemorrhage due* to left side</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>a linear fracture of skull, right posterior fossae due to a fall also had acute fatty liver.</b> DUE TO (c) <b>fossae due to a fall also had acute fatty liver.</b>  PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)														
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>														
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I) <b>Standing on bench in Jail cell, fell off &amp; hit head on concrete floor.</b>		20c. TIME OF INJURY Month, Day, Year Hour <b>5.05 a.m.—Sept. 24 1956</b>							20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>City Jail</b>		20f. (City or town) (County) (State) <b>Cumberland Allegany Md.</b>	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>														
ACTUAL SIGNATURE <b>H. V. Deming M.D.</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Sept. 24-1956							DATE SIGNED					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>9-27-56</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Philos Cemetery</b>		22d. LOCATION (City, town, or county) <b>Westernport, Md.</b>		(State)						
23. FUNERAL DIRECTOR'S SIGNATURE <b>E. Boal</b>		ADDRESS <b>Westernport, Md.</b>		24a. REC'D BY REGISTRAR <b>Sept. 26, 1956</b>		24b. REGISTRAR'S SIGNATURE <b>W. R. Gratz, M.D.</b>								

**BUREAU X**

SEP 28 1956

**REGEVIEW**

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08885

DR. LEY

Within corporate limits: CERTIFICATE OF DEATH

Reg. Dist. No. 4

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY ALLEGANY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND		b. COUNTY ALLEGANY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 5 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL		d. STREET ADDRESS 706 N. CENTRE ST.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) JOSEPH		First	Middle	Lost	4. DATE OF DEATH GRIM	Month SEPTEMBER	Day 23	Year 19 56
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. AGE (In years last birthday) yrs. 85	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Freight Conductor		10b. KIND OF BUSINESS OR INDUSTRY WM R. R.		11. BIRTHPLACE (State or foreign country) VIRGINIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME CHARLES H. GRIM		14. MOTHER'S MAIDEN NAME MARTHA E. TAYLOR						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT MEMORIAL HOSPITAL-MEMORIAL AND WARWICK AVES.		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]  PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)  157X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b)  DUE TO (c)  Carcinoma of Pancreas  INTERVAL BETWEEN ONSET AND DEATH								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20c. TIME OF INJURY Hour a. m. p. m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) 456 N. Centre St.	(County) Cumberland	(State) Md.		
21. I certify that I attended the deceased from <u>9/4</u> , 19 <u>56</u> , to <u>9/23</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>9/19</u> , 19 <u>56</u> , and that death occurred at <u>9:45 P.M.</u> from the causes and on the date stated above.								
ACTUAL SIGNATURE Physician's Name (Type) LEO H. LEY JR.	ADDRESS (Street, city or town, state) 456 N. Centre St. Cumberland, Md.						DATE SIGNED 9/24/56	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 9-26-1956	22c. NAME OF CEMETERY OR CREMATORIAL Davis Memorial Cemetery	22d. LOCATION (City, town, or county) Cumberland, Md.	(State)				
23. FUNERAL DIRECTOR'S SIGNATURE William H. Kight	ADDRESS Cumberland, Md.	24a. REC'D BY REGISTRAR Sept 26, 1956	24b. REGISTRAR'S SIGNATURE W.R. Frantz, M.D.					

BUREAU Y. S.  
RECEIVED

SEP 28 1956

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Within corporate limits

08886

8884

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH o. COUNTY Allegany		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland		b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 58 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 363 Bedford Street		d. STREET ADDRESS 363 Bedford Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			

3. NAME OF DECEASED (Type or print) CALVIN OTTO HAVER		First	Middle	Last	4. DATE OF DEATH Sept. 8, 1956	Month	Day	Year
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5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH Feb. 7, 1898	9. AGE (In years last birthday) 58 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Mach.	10b. KIND OF BUSINESS OR INDUSTRY B & O Railroad	11. BIRTHPLACE (State or foreign country) Cumberland, Maryland	12. CITIZEN OF WHAT COUNTRY? USA
--	--	--	----------------------------------

13. FATHER'S NAME Otto Hafer	14. MOTHER'S MAIDEN NAME Annie Kahl
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? No	16. SOCIAL SECURITY NO. 705-054344	17. INFORMANT Mrs. Newton Parrish	Address 363 Bedford St., Cumberland, Md.
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18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 157X DUE TO <i>Exhaustion Cancerous Tachycardia</i>		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO <i>Carcinoma Pancreas and liver</i>		6 mos
(c)		

Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
<i>Chronic Colitis about 10 years</i>		

20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.	20d. INJURY OCCURRED White Nat white at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 1946, 19, to Sept 8, 1956, that I last saw the deceased alive on Sept 8, 1956, and that death occurred at 11 p.m., from the causes and on the date stated above.

ACTUAL SIGNATURE *F. Alan G. Murray* M.D. ADDRESS (Street, city or town, state) La Vale, Md. DATE SIGNED Sept 10/56

PHYSICIAN'S NAME (Type) F. Alan G. Murray	M.D. La Vale, Maryland
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22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Sept. 11, 1956	22c. NAME OF CEMETERY OR CREMATORIUM Greenmount Cemetery	22d. LOCATION (City, town, or county) Cumberland, Maryland
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23. FUNERAL DIRECTOR'S SIGNATURE John J. Hafer, Cumberland, Maryland	ADDRESS	24a. REC'D BY REGISTRAR Sept. 11, 1956	24b. REGISTRAR'S SIGNATURE <i>W. Frank, M.D.</i>
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## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 1

## CERTIFICATE OF DEATH

1323

STATE OF MARYLAND

1323

RECEIVED  
MAY 21 1956

SEP 13 1956

RECEIVED

Within corporate limits

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial or removal.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

8885

088874

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Allegany</b>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) b. STATE Md. c. COUNTY <b>Allegany</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>434 Chestnut St.</b>		d. STREET ADDRESS <b>434 Chestnut St.</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <b>Lawrence</b>	Middle <b>J.</b>	Last <b>Harrigan</b>
4. DATE OF DEATH	Month <b>Sept</b>	Day <b>9</b>	Year <b>19 56</b>
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 6-1884</b>
9. AGE (In years last birthday) <b>71 yrs.</b>	10. IF UNDER 1 YEAR Months <b>0</b>	11. IF UNDER 24 HRS. Days <b>0</b>	12. IF UNDER 24 HRS. Hours <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Salesman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Queen City Candy Co.</b>	
11. BIRTHPLACE (State or foreign country) <b>Pittsburg, Pa.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Bartholomew Harrigan</b>		14. MOTHER'S MAIDEN NAME <b>Mary Buckley</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT (daughter) Willa Woods, Cumberland, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary occlusion</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Coronary sclerosis</b> DUE TO (c) <b>Arteriosclerosis</b>			
INTERVAL BETWEEN ONSET AND DEATH <b>sudden</b> over one year ?			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <i>H.V. Deming M.D.</i>		DATE SIGNED M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Sept 9-1956	
EXAMINER'S NAME (Type) <b>H.V. Deming M.D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>Sept. 12, 1956</b>	22c. NAME OF CEMETERY OR CREMATORIUM <b>Sts. Peter &amp; Paul Cemetery</b>	22d. LOCATION (City, town, or county) <b>Cumberland, Maryland.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>James F. Scarpelli, Cumberland, Maryland.</b>		ADDRESS <b>Scarpelli</b>	
24a. REC'D BY REGISTRAR <b>NOTE: Sept. 10, 1956</b>		24b. REGISTRAR'S SIGNATURE <b>W. Frantz M.D.</b>	

BUREAU V. S.

SEP 13 1956

RECEIVED

DR. SIMONS

8886

## CERTIFICATE OF DEATH

Reg. Dist. No.

4

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>PENNSYLVANIA</b>		b. COUNTY <b>Blair</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>62 CUMBERLAND</b>		c. LENGTH OF STAY IN 1b <b>4 HRS.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Altoona</b>		d. STREET ADDRESS <b>1103 THIRD STREET Juniata</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>60 MEMORIAL HOSPITAL</b>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <b>FRANCIS</b>	Middle <b>M.</b>	Last <b>HAZEY</b>	4. DATE OF DEATH	Month <b>SEPTEMBER</b>	Day <b>14</b>	Year <b>1956</b>
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <b>JANUARY 25 1888</b>	9. AGE (In years lost birthday) <b>68 yrs.</b>	IF UNDER 1 YEAR Months <b>0</b>	IF UNDER 24 HRS. Days <b>0</b>	Hours <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Tailor(Self Empl.)</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Clothing</b>		11. BIRTHPLACE (State or foreign country) <b>New Orleans, La.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>MICHAEL HAZEY</b>		14. MOTHER'S MAIDEN NAME <b>MARY GABRIEL</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>unknown</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>MEMORIAL HOSPITAL - CUMBERLAND, MD.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]  PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>451X</b> Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) DUE TO  (c) DUE TO  (d) DUE TO		<i>Ruptured Aorta (Abdominal) Aneurysm</i>				INTERVAL BETWEEN ONSET AND DEATH <b>8 hrs.</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour o. m.      p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that I attended the deceased from <b>9/13</b> , 19 <b>57</b> , to <b>9/14</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>9/14</b> , 19 <b>57</b> , and that death occurred at <b>12:05</b> PM, from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <b>George M. Simons, M.D., 128 Pleasant St., Cumberland, Md. 917152</b>		DATE SIGNED <b>Sept. 14, 1956</b>			
ACTUAL SIGNATURE <i>George M. Simons</i>		PHYSICIAN'S NAME (Type) <b>DR. G. SIMONS</b>		22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>9/17/56</b>	
22c. NAME OF CEMETERY OR CREMATORIUM <b>Calvary Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Altoona, Penna.</b>					
23. FUNERAL DIRECTOR'S SIGNATURE <b>Charles L. George Cumberland, Maryland</b>		ADDRESS <b>Charles L. George Cumberland, Maryland</b>		24a. REC'D BY REGISTRAR <b>Sept. 14, 1956</b>		24b. REGISTRAR'S SIGNATURE <b>Dr. Frank, M.D.</b>	

81 | ПОМІДОРЫ-ПІДСІДЛЯЧІ ТА ІІІ ВІДКРИТИЙ КОНКУРС

RECEIVED SEP 15 1956  
BUREAU V. S.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8932

## CERTIFICATE OF DEATH

088849

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Allegany</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Allegany</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frostburg</b>		c. LENGTH OF STAY IN lb <b>life</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>261 E. Main St.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Miners Hospital</b>		d. STREET ADDRESS <b>Frostburg</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>AGATHA</b>	First <b>R.</b>	Middle <b>IRWIN</b>	Last	4. DATE OF DEATH <b>Sept. 19, 1956</b>	Month	Day	Year
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH <b>8-20-1874</b>	9. AGE (in years last birthday) <b>82 yrs.</b>	IF UNDER 1 YEAR <b>Months Days</b>	IF UNDER 24 HRS. <b>Hours Min.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housework</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>own home</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Conrad Schneider</b>		14. MOTHER'S MAIDEN NAME <b>Rose Domdera</b>		Address			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT <b>Arthur Irwin, Frostburg, Md.</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>592X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>Uremia</b> ? ± 2 wks.	
{ b) DUE TO c)		<b>Cardiovascular Renal disease</b>		<b>? ± 12 yrs.</b>			
		<b>Chronic glomerulonephritis</b>		<b>+ 20 yrs</b>			
PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Decubitus + Rheumatism + Osteoarthritis - Hand, knees, spine</b>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.			
				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____		21. I certify that I attended the deceased from _____		21. I certify that I attended the deceased from _____		21. I certify that I attended the deceased from _____	
alive on _____		alive on _____		alive on _____		alive on _____	
ACTUAL SIGNATURE <b>Frank T. Harrat</b>		ADDRESS (Street, city or town, state) <b>26 Mechanic St., Frostburg, Md.</b>		DATE SIGNED <b>9-21-1956</b>			
PHYSICIAN'S NAME (Type) <b>FRANK T. HARRAT</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>9-21-1956</b>		22c. NAME OF CEMETERY OR CREMATORIAL <b>F' bg. Memorial Park</b>		22d. LOCATION (City, town, or county) <b>Frostburg, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>J. R. Durst,</b>		ADDRESS <b>Frostburg, Md.</b>		24a. REC'D BY REGISTRAR <b>D. Lancy N. Rae</b>		24b. REGISTRAR'S SIGNATURE <b>DATE 9-21-56</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

BUREAU V. A.

SEP 25 1956

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08890

Reg. Dist. No. 4

DR. DURRETT

8887

## CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>WEST VIRGINIA</b>		b. COUNTY <b>MINERAL</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>		c. LENGTH OF STAY IN 1b <b>6 DAYS</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RIDGELEY, Rural</b>		d. STREET ADDRESS <b>RT. #1</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MEMORIAL HOSPITAL</b>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)	First <b>JAMES</b>	Middle <b>HENRY</b>	Last <b>JOHNSTON</b>	4. DATE OF DEATH	Month <b>SEPT.</b>	Day <b>14</b>	Year <b>1956</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>JAN. 22, 1869</b>	9. AGE (In years last birthday) yrs. <b>89</b>	IF UNDER 1 YEAR Months <b>0</b>	IF UNDER 24 HRS. Days <b>0</b>	Hours <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Farm</b>		11. BIRTHPLACE (State or foreign country) <b>PENNSYLVANIA</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>PAUL JOHNSTON</b>		14. MOTHER'S MAIDEN NAME <b>MATILDA ELIZABETH KINSER</b>		Address <b>MEMORIAL HOSPITAL-MEMORIAL &amp; WARWICK AVES.</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)  DUE TO <b>Chronic Myocarditis</b> Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) <b>Broncho-Pneumonia</b> DUE TO (c)  PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		INTERVAL BETWEEN ONSET AND DEATH <b>5 days</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
21. I certify that I attended the deceased from <b>Sept. 8</b> , 1956, to <b>Sept. 14</b> , 1956, that I last saw the deceased alive on <b>Sept. 14</b> , 1956, and that death occurred at 7:30 P.M. from the causes and on the date stated above.		ACTUAL SIGNATURE <b>Clay E. Durrett</b>		ADDRESS (Street, city or town, state) <b>Clay E. Durrett, M.D., Cumberland - Md</b>		DATE SIGNED <b>9/15/56</b>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Sept. 17, 1956</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Georg Cemetery</b>		22d. LOCATION (City, town, or county) <b>Swanton, Maryland</b>		
23. FUNERAL DIRECTOR'S SIGNATURE <b>E. S. Boal, Westernport, Maryland.</b>		ADDRESS <b>VS A15 (4) ISM 9/55</b>		24a. REC'D BY REGISTRAR <b>Sept. 17, 1956</b>		24b. REGISTRAR'S SIGNATURE <b>W. Frank, M.D.</b>		

BUREAU V. S

SEP 19 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08891

Reg. Dist. No. 4

1. PLACE OF DEATH  
a. COUNTY

Allegany

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL  
and give nearest town)

Cumberland

4 yrs.

c. LENGTH OF STAY IN lb

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

D.O.A. Sacred Heart Hospital

99

3. NAME OF  
DECEASED  
(Type or print)First  
IdaMiddle  
JaneLast  
Jones4. DATE  
OF  
DEATHMonth  
Sept.Day  
6Year  
1956

5. SEX

Female

6. COLOR OR RACE

white

7. MARRIED NEVER MARRIED 

8. DATE OF BIRTH

Dec. 12-1880

9. AGE (In years  
last birthday)

75 yrs.

10. IF UNDER 1 YEAR

Months  
Days

11. IF UNDER 24 HRS.

Hours  
Min.10a. USUAL OCCUPATION (Give kind of work done  
during most of working life, even if retired)

Housewife

10b. KIND OF BUSINESS OR INDUSTRY

Own Home

11. BIRTHPLACE (State or foreign country)

Paw Paw, W. Va.

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Fred Dawson

14. MOTHER'S MAIDEN NAME

Emily Dunn

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no, or unknown)

no

16. SOCIAL SECURITY NO.

none

17. INFORMANT

George Schoenadel, Cumberland, Md.

Address

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a)

Myocardial failure

INTERVAL BETWEEN  
ONSET AND DEATH

sudden

DUE TO  
Conditions, if any, which  
gave rise to immediate cause  
(a), stating the underlying  
cause last.

(b)

DUE TO

(c)

Chronic myocarditis

Diabetes mellitus

Arteriosclerosis with hypertension

several yrs

10 yrs

?

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY  
PERFORMED?YES  NO 20a. EXTERNAL CAUSE WAS  
PRIMARY  or CONTRIBUTING   
CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year  
Hour o. m. p. m. 1920d. INJURY OCCURRED  
While  
of work  Not while  
of work 20e. PLACE OF INJURY (Home, farm,  
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I took charge of the remains described above, held an Autopsy , Inspection , Inquiry , and find that death resulted from: Natural causes , Accident , Suicide , Homicide , Undetermined cause .

MEDICAL CERTIFICATION

ACTUAL  
SIGNATUREEXAMINER'S  
NAME (Type)

H. V. Deming M.D.

M.D. CHIEF MEDICAL EXAMINER ASSISTANT MEDICAL EXAMINER DEPUTY MEDICAL EXAMINER 

DATE SIGNED

Sept. 6-1956

22a. BURIAL, CREMATION,  
REMOVAL (Specify)  
Burial Sept. 9, 1956 Hamill Cemetery

22d. LOCATION (City, town, or county) (State)

Kitzmiller, Maryland.

23. FUNERAL DIRECTOR'S SIGNATURE

ADDRESS  
Charles L. George, Cumberland, Maryland.

24a. REC'D BY REGISTRAR

Oct. 7, 1956

24b. REGISTRAR'S SIGNATURE

W.L. Frantz M.D.

RECEIVED EXHIBIT 9. CIRCUMSTANCES OF  
STATE GOVERNMENT OF HAWAII - DEPARTMENT OF

BUREAU V. S.

SEP 10 1956

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08892

8889

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b>		b. COUNTY <b>ALLEGANY</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>		c. LENGTH OF STAY IN 1b <b>13 DAYS</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>		d. STREET ADDRESS <b>491 BALTIMORE AVENUE</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SACRED HEART HOSPITAL</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <b>JAMES R. KELLER</b>		First	Middle	Last	4. DATE OF DEATH <b>SEPTEMBER 22 1956</b>	Month	Day	Year
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <b>MARCH 1, 1901</b>	9. AGE (In years last birthday) <b>55</b> yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days	12. IF UNDER 24 HRS. Hours	13. IF UNDER 24 HRS. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>CLERK</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>R&amp;O RR Railroad</b>		11. BIRTHPLACE (State or foreign country) <b>WEST VIRGINIA</b>		12. CITIZEN OF WHAT COUNTRY? <b>Martinsburg, USA</b>		
13. FATHER'S NAME <b>DANIEL KELLER (DECEASED)</b>		14. MOTHER'S MAIDEN NAME <b>DORA STEPHENS (DECEASED)</b>		Address				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. <b>226-09-8812</b>		17. INFORMANT <b>PATIENTS CHART</b>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary infarction</b>		DUE TO <b>Cardiac Fibrosis due to coronary infarction</b>		INTERVAL BETWEEN ONSET AND DEATH <b>28 days</b>				
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>420.1</b>		DUE TO <b>(c)</b>		DUE TO <b>Since Feb 20, 1956</b>				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour o. m. p. m.	Month 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <b>Winchester, Va.</b>	(County) <b>Winchester, Va.</b>	(State) <b>VA</b>		
21. I certify that I attended the deceased from <b>Aug 25, 1956</b> , to <b>Sept 22, 1956</b> , that I last saw the deceased alive on <b>Sept 22, 1956</b> , and that death occurred at <b>11 P.M.</b> from the causes and on the date stated above.				ADDRESS (Street, city or town, state) <b>Winchester, Va.</b>		DATE SIGNED <b>Sept 23, 1956</b>		
ACTUAL SIGNATURE <b>R.W. Treavaskis, Jr.</b>	M.D.							
PHYSICIAN'S NAME (Type) <b>R.W. TREAVASKIS, JR.</b>	Cumberland, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>9-25-56</b>	22c. NAME OF CEMETERY OR CREMATORIUM <b>Mt. Hebron Cem.</b>	22d. LOCATION (City, town, or county) <b>Winchester, Va.</b>					
23. FUNERAL DIRECTOR'S SIGNATURE <b>James F. Scarpelli</b>		ADDRESS <b>Cumberland, Md.</b>	24a. RECD BY REGISTRAR <b>Sept. 24, 1956</b>	24b. REGISTRAR'S SIGNATURE <b>W.R. Frank, M.D.</b>				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS AIS (4)  
1SM 9/55

002

CERTIFICATE OF DEATH

BUREAU V. S.

SEP 26 1956

REGISTRY

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death: Page 4  
 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8933

## CERTIFICATE OF DEATH

108893

Reg. Dist. No. 9

1. PLACE OF DEATH a. COUNTY  Allegany		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg		c. LENGTH OF STAY IN 1b 30 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 6 Chestnut St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First DAVID	Middle L.	Last KIDDY
4. DATE OF DEATH	Month Sept.	Day 24,	Year 19 56
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-22-1900
9. AGE (In years lost birthday) 55 yrs.		10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) engineering dept.		10b. KIND OF BUSINESS OR INDUSTRY Celanese Corp.	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Matthew Kiddy		14. MOTHER'S MAIDEN NAME Annie Stark	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 216-05-5764	
17. INFORMANT Mrs. Tracy Kiddy, Frostbur, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]  PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Coronary occlusion Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) Moderate arterio-sclerosis (c) Several years.		INTERVAL BETWEEN ONSET AND DEATH 1/2 hr.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m.	Month, Day, Year 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County)	(State)		
21. I certify that I attended the deceased from <u>9-24</u> , 19 <u>56</u> , to <u>9-24</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>9-24</u> , 19 <u>56</u> , and that death occurred at <u>11145</u> M, from the causes and on the date stated above. ACTUAL SIGNATURE <u>H.C. Dietl</u> M.D. ADDRESS (Street, city or town, state) <u>Frostburg, Md.</u> DATE SIGNED <u>9/24/56</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-27-56	22c. NAME OF CEMETERY OR CREMATORIUM F'bg. Memorial Park
22d. LOCATION (City, town, or county) Frostburg, Md.		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE J. R. Durst,		ADDRESS Frostburg, Md.	24a. REC'D BY REGISTRAR DATE <u>9-27-56</u>
			24b. REGISTRAR'S SIGNATURE Dw. Dauncy N. Rae

## CERTIFICATE OF DEATH

BUREAU V. S.

OCT 1 1956

RECEIVED

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician.  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8899

## CERTIFICATE OF DEATH

08894

Reg. Dist. No. 4

1. PLACE OF DEATH a. COUNTY <b>Allegany</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Allegany</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>		c. LENGTH OF STAY IN 1b <b>2 years</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Hammond Nursing Home 79 Greene St.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		d. STREET ADDRESS <b>79 Greene St.</b>		e. DATE OF DEATH <b>Sept. 14 1956</b>	
3. NAME OF DECEASED (Type or print) <b>AMALIE.</b>		First	Middle	Last	Month	Day	Year
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 14, 1872</b>	9. AGE (In years lost birthday) <b>84 yrs.</b>	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (State or foreign country) <b>Germany</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Carl Oswald</b>		14. MOTHER'S MAIDEN NAME <b>Dora Miller</b>		Address			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>otto R. Schierenbeck, Cumberland, Md.</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>generalized arteriosclerosis, cerebral arteriosclerosis</b> DUE TO 334X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____	
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>old age</b>						INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 1954, to 9/14, 1956, that I last saw the deceased alive on 9/14, 1956, and that death occurred at 1120 P.M., from the causes and on the date stated above.		ADDRESS (Street, city or town, state)		DATE SIGNED			
ACTUAL SIGNATURE <i>Elizabeth Brings</i>		M.D.					
PHYSICIAN'S NAME (Type) <b>ELIZABETH BRINGS</b>		22c. NAME OF CEMETERY OR CREMATORIAL <b>55 GREENE ST. CUMBERLAND MD.</b>		22d. LOCATION (City, town, or county) <b>Bronx, New York, N. Y.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Sept. 18, 1956</b>		22c. NAME OF CEMETERY OR CREMATORIAL <b>Woodlawn Cemetery</b>		22d. LOCATION (City, town, or county) <b>Bronx, New York, N. Y.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Byron Right</i>		ADDRESS <b>Cumberland, Md.</b>		24a. REG'D. BY REGISTRAR DATE <b>Sept. 18, 1956</b>		24b. REGISTRAR'S SIGNATURE <i>W.L. Frank, M.D.</i>	

## CERTIFICATE OF DEATH

1928

NAME

ADDRESS

CITY

STATE

ZIP

PHONE

FBI  
BUREAU

WISCONSIN

SEP 19 1956

RECEIVED

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**8948 MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

08895

Reg. Dist. No. 8

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial or removal.

1. PLACE OF DEATH o. COUNTY <b>Allegany</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Allegany</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Lonaconing</b>		c. LENGTH OF STAY IN 1b <b>30 yrs.</b>	
d. NAME OF PERSONAL INSTITUTION (Not in hospital, give street address) <b>Rural Mountain area</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Lonaconing</b>	
D.O.A. at Dr. Miles office.		d. STREET ADDRESS <b>Beechwood St.</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <b>Stanley</b>	Middle <b>E.</b>	Last <b>Lancaster</b>
4. DATE OF DEATH	Month <b>Sept.</b>	Day <b>28</b>	Year <b>19 56</b>
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 10-1902</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer - Koontz Coal Co.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Avilton, Md.</b>	
11. BIRTHPLACE (State or foreign country) <b>U.S.A.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Elmer Lancaster</b>		14. MOTHER'S MAIDEN NAME <b>Florence Wampler</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>217-03-2029</b>	
17. INFORMANT <b>(wife) Mrs. S.E. Lancaster, Lonaconing, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Coronary occlusion</b>			
420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Coronary osteo occlusion			
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)			
20c. TIME OF INJURY Hour o. m. p. m. 19		Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>Moscow,</b>	(County) <b>Md.</b>
(State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/>			
ACTUAL SIGNATURE <i>H.V. Deming M.D.</i>	DATE SIGNED <b>Sept- 29-1956</b>		
EXAMINER'S NAME (Type) <b>H.V. Deming M.D.</b>	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>10/2/56</b>	22c. NAME OF CEMETERY OR CREMATORIUM <b>Laurel Hill Cemetery</b>	22d. LOCATION (City, town, or county) <b>Moscow,</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>George Eichhorn</b>		ADDRESS <b>Lonaconing, Md.</b>	24a. REC'D BY REGISTRAR <b>10-1-56</b>
		24b. REGISTRAR'S SIGNATURE <i>Jeanette M. Boul</i>	

BUREAU V. 5

1956 5 OCT

REGELVÉD

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

108896

8934

## CERTIFICATE OF DEATH

Reg. Dist. No. 9

1. PLACE OF DEATH a. COUNTY <b>Alleghany</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b>		b. COUNTY <b>Alleghany</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frostburg</b>		c. LENGTH OF STAY IN 1b <b>3 Days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Vale Summit, Frostburg</b>		d. STREET ADDRESS <b>R. D. No 1</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Niner's Hospital</b>				e. IS RESIDENCE ON A FARM? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				
3. NAME OF DECEASED (Type or print) <b>James</b>	First	Middle	Last	4. DATE OF DEATH <b>9 6 1956</b>	Month	Day	Year	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7-25-1889</b>	9. AGE (In years lost birthday) <b>67 yrs.</b>	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Janitor</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Celanese</b>		11. BIRTHPLACE (State or foreign country) <b>Vale Simmit</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>Martin Lavelle</b>				14. MOTHER'S MAIDEN NAME <b>Margaret Finn</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO. <b>220-10-2747</b>		17. INFORMANT <b>Thomas M. Lavelle, R. D. No 1, Frostburg</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>200X</b> (b) DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b>				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Diabetes</b>								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>None</b>						19. WAS AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO
20c. TIME OF INJURY Hour a. m. p. m.	Month 19	Day	Year	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <b>Frostburg</b>	(County) <b>Md.</b>	(State) <b>Md.</b>
21. I certify that I attended the deceased from <b>Sept 5, 1956</b> to <b>Sept 6, 1956</b> , that I last saw the deceased alive on <b>Sept 5, 1956</b> , and that death occurred at <b>10 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Frostburg</b> DATE SIGNED <b>Sept 7, 1956</b>								
ACTUAL SIGNATURE <b>WOM Lane</b>	M.D.							
PHYSICIAN'S NAME (Type) <b>WOM Lane</b>								
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>9-8-1956</b>	22c. NAME OF CEMETERY OR CREMATORIAL <b>St. Michael's Cemetery</b>	22d. LOCATION (City, town, or county) <b>Frostburg</b>	(State) <b>Md.</b>				
23. FUNERAL DIRECTOR'S SIGNATURE <b>Bertha H. Monticash</b>		ADDRESS <b>HAFFER FUNERAL HOME 23 E. MAIN, FROSTBURG</b>	24a. REC'D BY REGISTRAR <b>DAT 9-8-56</b>	24b. REGISTRAR'S SIGNATURE <b>Mary A. Lee</b>				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

GENERAL STATE GOVERNMENT - BUREAU OF DEATH  
CERTIFICATE OF DEATH

NAME

BUREAU V.

SEP 17 1956

RECEIVED

Within corporate limits

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08897 4

8891

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY  Alleghany		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Alleghany		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 11 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cresaptown		d. STREET ADDRESS		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Sacred Heart Hospital						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) Mary		First	Middle	Last	4. DATE OF DEATH 9/17/1956	Month	Day	Year
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 3/21/08	9. AGE (In years lost birthday) 58 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Cresaptown, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Edward Shook			14. MOTHER'S MAIDEN NAME Agnes Lease			Address		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO			16. SOCIAL SECURITY NO. None			17. INFORMANT Chart		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (g) 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (o), stating the underlying cause lost. 260.1 (b) Congestive Heart failure DUE TO (c) Coronary heart disease			71 Hemorrhage			INTERVAL BETWEEN ONSET AND DEATH 2 mo.		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o) Diabetes mellitus						6 mo.		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) none			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20c. TIME OF INJURY Hour a. m. p. m.	Month May 19	Doy 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 140 Bedford St. Cumberland	20f. (City or town) Maryland	(County)	(State)	
21. I certify that I attended the deceased from May 14, 1956, to Sept 17, 1956, that I last saw the deceased alive on 9-17-56, and that death occurred on 9-20-56 M. from the causes and on the date stated above.								
ACTUAL SIGNATURE T.P. Haferman MD				ADDRESS (Street, city or town, state) 140 Bedford St. Cumberland		DATE SIGNED 9-18-56		
PHYSICIAN'S NAME (Type) T.P. Haferman MD				Maryland				
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 9/19/56	22c. NAME OF CEMETERY OR CREMATORIUM Lease Cemetery	22d. LOCATION (City, town, or county) Cresaptown, Maryland		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE John J. Hafer, Cumberland, Maryland			24a. REC'D BY REGISTRAR Sept 19, 1956		24b. REGISTRAR'S SIGNATURE W.R. Frank, M.D.			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4  
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED  
FEBRUARY 21 1956

SEP 21 1956

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 08898

8892

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b>		b. COUNTY <b>ALLEGANY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>		c. LENGTH OF STAY IN lb <b>10 DAYS</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>		d. STREET ADDRESS <b>215 FEDERAL STREET</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>MEMORIAL HOSPITAL</b>				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First <b>RANDY</b>	Middle <b>DALE</b>	Last <b>LEWIS</b>	4. DATE OF DEATH Month <b>9-</b> Day <b>4</b> Year <b>19 56</b>		
S. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	B. DATE OF BIRTH <b>7-10-56</b>	9. AGE (In years lost birthday) yrs. <b>2</b>	IF UNDER 1 YEAR Months <b>2</b>	IF UNDER 24 HRS. Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>CUMBERLAND, MD.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>JAMES LEWIS</b>				14. MOTHER'S MAIDEN NAME <b>LEONA WARNER</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>MEMORIAL HOSPITAL</b>		Address <b>MEMORIAL AVENUE</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>754.3</b> <i>Congenital Heart Disease (Transposition of Great Vessels)</i> INTERVAL BETWEEN ONSET AND DEATH <b>2nd.</b>							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>(with inter atrial septal defect)</i>							
DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>aspiration pneumonia and septicemia</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Aug 25, 1956</b> , to <b>Sept 4, 1956</b> , that I last saw the deceased alive on <b>Sept 3, 1956</b> , and that death occurred at <b>6:40A.M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Ralph A. Reiter, M.D.</b> ADDRESS (Street, city or town, state) <b>112 Belford St.</b> DATE SIGNED							
PHYSICIAN'S NAME (Type) <b>DR. RALPH REITER</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>9-5-56</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>SS Peter &amp; Paul</b>		22d. LOCATION (City, town, or county) (State) <b>Cumberland, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>James B. Scarpelli</b> ADDRESS <b>Cumberland, Md.</b>				24a. REC'D. BY REGISTRAR <b>Sept 5, 1956</b>		24b. REGISTRAR'S SIGNATURE <b>W. L. Hartz, M.D.</b>	

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## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 FilmG202 9-13-56 et

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## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Allegany</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland,</b>		c. LENGTH OF STAY IN 1b <b>1 Mo 6 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>		d. STREET ADDRESS <b>St. Peter &amp; Paul's Monastery</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Sacred Heart Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <b>Father</b>	Middle <b>Hilary</b>	Last <b>Liehr</b>	4. DATE OF DEATH <b>1 9</b>	Month <b>9</b>	Day <b>3</b>	Year <b>1956</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 16, 1892</b>	9. AGE (In years last birthday) <b>61 8</b>	IF UNDER 1 YEAR Months <b>6</b>	IF UNDER 24 HRS. Days <b>8</b>	Hours <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Pastor Catholic Ch.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Priesthood</b>		11. BIRTHPLACE (State or foreign country) <b>Pittsburgh, Pa.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Robert Liehr</b>				14. MOTHER'S MAIDEN NAME <b>Agnes Arlt</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO. 17. INFORMANT <b>Mrs. Lydia Loscar, Compton, Calif.</b>			
Address							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.0</b>				INTERVAL BETWEEN ONSET AND DEATH <b>45 days</b>			
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. <b>Pulmonary Embolism</b>				45 day			
DUE TO <b>(b) Hypertension and arteriosclerotic heart disease 2 years</b>				2 years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m.		Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.)	20f. (City or town) <b>Cumberland</b>	(County) <b>Calvert</b>	(State) <b>Md.</b>
21. I certify that I attended the deceased from <b>21 July 1956</b> , to <b>3 Sept. 1956</b> , that I last saw the deceased alive on <b>3 Sept. 1956</b> , and that death occurred at <b>8:30 A.M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>W. Alfred Van Ormer</b>				ADDRESS (Street, city or town, state) <b>Cumberland, Md.</b> DATE SIGNED <b>5 Sept. 1956</b>			
22a. PHYSICIAN'S NAME (Type) <b>W. Alfred Van Ormer, M.D.</b>		22b. DATE THEREOF <b>9-7-56</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>St. Augustine Cemetery</b>		22d. LOCATION (City, town, or county) <b>Millvale, Penna.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>James F. Scarpelli, Cumberland, Md.</b>				24a. REG'D BY REGISTRAR <b>Sept. 5, 1956</b>			
				24b. REGISTRAR'S SIGNATURE <b>Winter R. Frank, M.D.</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-trust permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V.

SEP 6 1956

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## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08900

Within corporate limits

8894

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death; Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>		c. LENGTH OF STAY IN 1b <b>233 DAYS</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b>		b. COUNTY <b>ALLEGANY</b>					
d. NAME OF HOSPITAL OR INSTITUTION <b>MEMORIAL HOSPITAL MEMORIAL &amp; WARWICK AVES</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>		f. STREET ADDRESS <b>323 X882 GREENE STREET</b>		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <b>SARAH</b>		First	Middle	Last	4. DATE OF DEATH <b>LOGSDON</b>	Month	Day	Year					
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>OCTOBER 7, 1882</b>	9. AGE (In years last birthday) <b>78 yrs.</b>	10. IF UNDER 1 YEAR Months <b>0</b>	11. IF UNDER 24 HRS. Days <b>0</b>	Hours <b>0</b>	Min. <b>0</b>					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own home</b>		11. BIRTHPLACE (State or foreign country) <b>Bridgewater, Penna.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>							
13. FATHER'S NAME <b>ISSAC MARTIN</b>		14. MOTHER'S MAIDEN NAME <b>CATHERINE Arthur</b>		Address <b>James Logsdon 323 Greene St., Cumberland, Md.</b>									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No,</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Chronic Myocarditis</b> DUE TO <b>443X</b> Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			INTERVAL BETWEEN ONSET AND DEATH <b>1 yr.</b>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ 19 _____ p. m. _____					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>—</b>	20f. (City or town) <b>—</b>	(County) <b>—</b>	(State) <b>—</b>
21. I certify that I attended the deceased from <b>9/1/55</b> , 19_____, to <b>9/1/56</b> , 19_____, that I last saw the deceased alive on <b>9/1/55</b> , 19_____, and that death occurred at <b>11:22 AM</b> from the causes and on the date stated above.							ADDRESS (Street, city or town, state) <b>—</b>					DATE SIGNED <b>9/1/56</b>	
ACTUAL SIGNATURE <b>RICHARD J. WILLIAMS</b>		PHYSICIAN'S NAME (Type) <b>RICHARD J. WILLIAMS</b>		22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>					22b. DATE THEREOF <b>9/11/56</b>	22c. NAME OF CEMETERY OR CREMATORIUM <b>Frostburg Memorial Park</b>	22d. LOCATION (City, town, or county) <b>Frostburg, Maryland</b>	(State) <b>—</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>H. Wayne George</b>		ADDRESS <b>Cumberland, Md.</b>		24a. REC'D BY REGISTRAR <b>9/11/56</b>		24b. REGISTRAR'S SIGNATURE <b>W.R. Franky, M.D.</b>							



Within corporate limits

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08901

8895

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY  Allegany		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE b. COUNTY  Maryland Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 2 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Sacred Heart Hospital		e. STREET ADDRESS 515 Schriver Ave.	
3. NAME OF DECEASED (Type or print) First Middle Last Ellen Cecelia Mattingly		4. DATE OF DEATH Month Day Year Sept. 13 1956	
5. SEX Female White		6. COLOR OR RACE WIDOWED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
7. MARRIED <input type="checkbox"/>		8. DATE OF BIRTH Feb. 11, 1884	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housekeeper at home		10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Michael Ready		14. MOTHER'S MAIDEN NAME Anna Lynch	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Husband Joseph Mattingly		Address Same as above	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Embolism 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) Cerebral Arteriosclerosis DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Sept. 10, 1956, to Sept. 13, 1956, that I last saw the deceased alive on Sept. 13, 1956, and that death occurred at 3:50 P.M., from the causes and on the date stated above. ACTUAL SIGNATURE: <i>Samuel Jacobson</i> M.D. ADDRESS (Street, city or town, state) DATE SIGNED 50 Peabody Street, Cumberland, Md.—9-14-56			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/17/56	
22c. NAME OF CEMETERY OR CREMATORIUM St. Peters & Pauls		22d. LOCATION (City, town, or county) Cumberland, Md. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE H. Lee Silcox Cumberland, Md.		24a. REG'D BY REGISTRAR DATE Sept. 14, 1956 W.R. Franky M.D.	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-trust permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to a burial, cremation, or removal, and in any event within 72 hours after death.

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## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

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## CERTIFICATE OF DEATH

08902

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Allegany</b>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Allegany</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frostburg</b>		c. LENGTH OF STAY IN 1b <b>Lifetime</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Miner's Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Anna Mae</b>	First <b>A</b>	Middle <b>McGann</b>	Last <b>9</b>		
4. DATE OF DEATH <b>Sept. 26 1895</b>	Month <b>25</b>	Day <b>1956</b>	Year		
5. SEX <b>F.</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <b>Sept. 26 1895</b>		
9. AGE (In years last birthday) <b>60 yrs.</b>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House Work</b>	11. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		
13. FATHER'S NAME <b>James McAteer</b>	14. MOTHER'S MAIDEN NAME <b>Mary Tippen</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>	16. SOCIAL SECURITY NO. <b>None</b>	17. INFORMANT <b>Mrs. Paul Fair, 7 Blair St. Frostburg, Md.</b>	Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Insufficiency</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>Hypertension</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 mo</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20c. TIME OF INJURY Month, Day, Year Hour a. m.      p. m. 19	20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Frostburg</b>	20f. (City or town) <b>Frostburg</b>	(County) <b>Md.</b>	(State) <b>Md.</b>
21. I certify that I attended the deceased from <b>Aug 1</b> , 1956, to <b>Sept 24</b> , 1956, that I lost sight of the deceased alive on <b>Sept 24</b> , 1956, and that death occurred on <b>Sept 26</b> , 1956, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Frostburg</b>					
ACTUAL SIGNATURE <b>Wm. Lane</b>	PHYSICIAN'S NAME (Type) <b>Wm. Lane</b>	M.D.	DATE SIGNED <b>Sept 26 1956</b>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>9/28/56</b>	22c. NAME OF CEMETERY OR CREMATORIAL ADDRESS <b>St. Michael's Cemetery Frostburg</b>	22d. LOCATION (City, town, or county) <b>Frostburg</b>	(State) <b>Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Beulah H. Winters</b>	24a. REC'D BY REGISTRAR <b>Hafer Funeral Home</b>	24b. REGISTRAR'S SIGNATURE <b>Stanley H. Roe</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## CERTIFICATE OF DEATH

NAME

BUREAU V. S.

OCT 3 1956

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 08903

Within corporate limits

8896

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland 2 yrs 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Patterson Ave.		d. STREET ADDRESS Patterson Ave.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) THOMAS	First N.	Middle McGRAW	4. DATE OF DEATH 9/28/1956 Month Day Year 19
S. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/15/1877
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Miner		10b. KIND OF BUSINESS OR INDUSTRY Coal Mine	
11. BIRTHPLACE (State or foreign country) Piedmont, W Va.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John McGraw		14. MOTHER'S MAIDEN NAME Margaret Reynolds	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 17. INFORMANT Address	
No		Mrs. Patrick Creegan, Cumberland, MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 493X DUE TO <i>Pneumonia</i>		INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Secondary Anemia</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ M. from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED	
ACTUAL SIGNATURE <i>Leo H. Ley Jr.</i>	M.D. 452 N. Centre St.		<i>9/29/56</i>
PHYSICIAN'S NAME (Type) LEO H. LEY JR.	Cumberland, Md.		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 10/1/1956	22c. NAME OF CEMETERY OR CREMATORIAL St Micheals Cemetery	22d. LOCATION (City, town, or county) Frostburg, MD. (State)
23. FUNERAL DIRECTOR'S SIGNATURE GEORGE EIGHORN	ADDRESS LONA CONING? MD.	24a. REC'D BY REGISTRAR DATE Oct. 1/1956	24b. REGISTRAR'S SIGNATURE W. P. Tracy, M.D.

BUREAU V. S.

OCT 3 1956

RECEIVED

With corporate limits

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

18904

DR. WEISMAN

8897

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Please remove carbon papers. Pages 1 and 2 should be filed with the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b>		b. COUNTY <b>ALLEGANY</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>02 CUMBERLAND</b>		c. LENGTH OF STAY IN lb <b>1 DAY</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>600 MEMORIAL HOSPITAL</b>		d. STREET ADDRESS <b>312 VIRGINIA AVENUE</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <b>KATHRYN</b>		First <b>B</b>	Middle <b>MC HUGH</b>	Last	4. DATE OF DEATH <b>SEPTEMBER 13, 1956</b>	Month	Day	Year	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>AUGUST 12, 1879</b>		9. AGE (In years (and birthday) <b>77 yrs.</b>	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>OWN HOME</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>MC HUGH, JOHN</b>			14. MOTHER'S MAIDEN NAME <b>ANNA HOLLEN</b>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>MEMORIAL HOSPITAL - CUMBERLAND, MD.</b>		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]  PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>HEART FAILURE, LEFT + RIGHT</b> DUE TO <b>420.0</b> INTERVAL BETWEEN ONSET AND DEATH <b>6 wks</b>  Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>HEART DISEASE - ARTERIOSCLEROTIC 10 yrs</b> DUE TO (c) <b>and Old RHEUMATIC</b>									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>UREMIA DUE TO RENAL FAILURE</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>Westernport</b> (County) <b>Md.</b> (State) <b>Westernport, Md.</b>			
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, and that death occurred at _____, from the causes and on the date stated above.						ADDRESS (Street, city or town, state) <b>59 GREENE ST</b> DATE SIGNED <b>9/13/56</b>			
ACTUAL SIGNATURE <b>H. Goldstein</b> M.D.									
PHYSICIAN'S NAME (Type) <b>S G WEISMAN MD</b>						CUMBERLAND MARYLAND			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Sept. 15, 1956</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>St. Peter's Cemetery</b>		22d. LOCATION (City, town, or county) <b>Westernport, Md.</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>James F. Scarpelli</b>						ADDRESS <b>Cumberland, Md.</b> 24a. REC'D BY REGISTRAR <b>Sept. 14, 1956</b> 24b. REGISTRAR'S SIGNATURE <b>J.W. Gratz, M.D.</b>			

WISCONSIN STATE DEPARTMENT OF HEALTH - DIVISION OF

CERTIFICATE OF DEATH

REGISTRATION

SEARCHES

INDEXES

FILED

RECORDED

SEARCHED

INDEXED

FILED

RECORDED

BUREAU U.S.  
RECEIVED  
SEP 21 1941

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

08905

Reg. Dist. No. 8

**8949**

1. PLACE OF DEATH  
o. COUNTY

**Allegany**

**MARYLAND**

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

**Gilmore**

c. LENGTH OF STAY IN lb

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

**Rt. #36 Highway**

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)

o. STATE **Md.**

b. COUNTY **Allegany**

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

**Cumberland**

d. STREET ADDRESS

**510 Woodside Ave**

e. IS RESIDENCE  
ON A FARM? \*  
YES  NO

3. NAME OF  
DECEASED  
(Type or print)

First  
**John**

Middle  
**Godfrey**

Last  
**Merrbach**

4. DATE  
OF  
DEATH

Month  
**Sept**

Day  
**9**

Year  
**1956**

5. SEX

6. COLOR OR RACE

7. MARRIED  NEVER MARRIED

WIDOWED

DIVORCED

8. DATE OF BIRTH

**Oct. 4-1911**

9. AGE (in years  
last birthday)

**44**

yrs.

10. IF UNDER 1YEAR

11. IF UNDER 24 HRS.

Months  
**0**

Days  
**0**

Hours  
**0**

Min.  
**0**

10a. USUAL OCCUPATION (Give kind of work done  
during most of working life, even if retired)

**Shoe repair man**

10b. KIND OF BUSINESS OR INDUSTRY

**Repairing shoes**

11. BIRTHPLACE (State or foreign country)

**Frostburg, Md.**

12. CITIZEN OF WHAT COUNTRY?

**U.S.A.**

13. FATHER'S NAME

**Emory Merrbach**

14. MOTHER'S MAIDEN NAME

**Mary (Unknown)**

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no, or unknown)  
(If yes, give war or dates of service)

**no**

16. SOCIAL SECURITY NO.

**000-00-0000**

17. INFORMANT

**(wife) Elizabeth Merrbach, Cumberland, Md.**

Address

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a)

**Intrathoracic hemorrhage due to a crushed**

INTERVAL BETWEEN  
ONSET AND DEATH

**sudden**

**819X**

Conditions, if any, which  
gave rise to immediate cause  
(a), stating the underlying  
cause last.

DUE TO

**chest, left side, also had a fracture of right**

**frontal bone, nose, left humerus & left femur.**

DUE TO

**(b) Auto accident.**

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY  
PERFORMED?

YES  NO

20c. EXTERNAL CAUSE WAS  
PRIMARY  OR CONTRIBUTING   
CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

**Driving north, ran in edge of concrete bridge, west side.**

20c. TIME OF INJURY Month, Day, Year  
Hour a. m. **1.20 p.m.-9-9**

20d. INJURY OCCURRED  
While at work  Not while at work

20e. PLACE OF INJURY (Home, farm,  
factory, street, office bldg., etc.)

20f. (City or town)  
(County) **Gilmore Allegany Md**

21. I certify that I took charge of the remains described above, held on Autopsy , Inspection , Inquiry  and find that death resulted from: Natural causes , Accident , Suicide , Homicide , Undetermined cause .

ACTUAL  
SIGNATURE

**H.V. Deming M.D.**

DATE SIGNED

EXAMINER'S  
NAME (Type)

**H.V. Deming M.D.**

M.D. CHIEF MEDICAL EXAMINER

ASSISTANT MEDICAL EXAMINER

DEPUTY MEDICAL EXAMINER

Sept 9-1956

22a. BURIAL, CREMATION,  
REMOVAL, (Specify)

**Burial**

22b. DATE THEREOF

**Sept. 10, 1956**

22c. NAME OF CEMETERY OR CREMATORIUM

**Hillcrest Cemetery**

22d. LOCATION (City, town, or county)

**Cumberland, Maryland**

(State)

23. FUNERAL DIRECTOR'S SIGNATURE

ADDRESS  
**William H. Kight, Cumberland, Maryland.**

24a. REC'D BY REGISTRAR

**Sept 11, 1956**

24b. REGISTRAR'S SIGNATURE

**Jeanette M. Boul**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial/transit permit. File Pages 1 and 2 with the registrar prior to burial or removal.

VS. A1SME(S)  
SM 9/55

RECEIVED  
FBI - NEW YORK  
SEPTEMBER 19 1956

WISCONSIN STATE DEPARTMENT OF LABOR  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

RECEIVED  
FBI - NEW YORK  
SEPTEMBER 19 1956

RECEIVED  
FBI - NEW YORK  
SEPTEMBER 19 1956

RECEIVED  
FBI - NEW YORK  
SEPTEMBER 19 1956

RECEIVED

SEP 19 1956

BUREAU V. S.

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4  
 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 24 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 8950 CERTIFICATE OF DEATH

08906

Reg. Dist. No. 6

1. PLACE OF DEATH o. COUNTY Allegany		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) o. STATE Md.		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural 4 Mi N. Westernport		c. LENGTH OF STAY IN lb 60 yrs		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural 4 Mi N. Westernport		
3. NAME OF DECEASED (Type or print) Clementina		Middle Name Michael	4. DATE OF DEATH Sept 27 1956	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 18, 1875	
9. AGE (In years at birthday) 81 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife	10b. KIND OF BUSINESS OR INDUSTRY own home	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Jarvis Custer		14. MOTHER'S MAIDEN NAME Amanada Magruder		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO.	17. INFORMANT Address Charles Michael-Westernport, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <i>Artherosclerotic heart disease</i>		INTERVAL BETWEEN ONSET AND DEATH <i>4 years</i>		
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Arteriosclerosis</i>		2.		
DUE TO (c)				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>January</i> , 1956, to <i>Sept 27, 1956</i> , that I last saw the deceased alive on <i>Sept 27, 1956</i> , and that death occurred at <i>9 P.M.</i> from the causes and on the date stated above.				ADDRESS (Street, city or town, state) <i>Piedmont W. Va</i>
ACTUAL SIGNATURE <i>James Al Washington Jr.</i>		M.D.		DATE SIGNED <i>9-29-56</i>
PHYSICIAN'S NAME (Type)				
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/30/56	22c. NAME OF CEMETERY OR CREMATORIUM Philos	22d. LOCATION (City, town, or county) (State) Westernport Md.
23. FUNERAL DIRECTOR'S SIGNATURE <i>E. B. Boul</i>		ADDRESS Westernport, Md.	24a. REC'D BY REGISTRAR DATE 9-30-56	24b. REGISTRAR'S SIGNATURE <i>Jean C Kelly</i>

## CERTIFICATE OF DEATH

STATE  
1952

DEATH

NAME

ADDRESS

BUREAU V. S.

OCT 3 1952

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08907

DR. SCHINDLER 8898

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>		c. LENGTH OF STAY IN 1b <b>5 DAYS</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MEMORIAL HOSPITAL</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>	
3. NAME OF DECEASED (Type or print) <b>JENNIE</b>		4. DATE OF DEATH Month <b>SEPTEMBER</b> Day <b>5</b> Year <b>1956</b>	
First <b>R.</b> Middle <b>MILLER</b>		5. SEX <b>FEMALE</b>	
6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <b>AUGUST 20, 1871</b>		9. AGE (In years lost/birthday) <b>85 yrs.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own home</b>	
11. BIRTHPLACE (State or foreign country) <b>Whitehall, Penna.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Charles Stofflett</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No,</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Mr. Harold K. Miller</b>		Address <b>Memorial Hospital, Cumberland, MD</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>170X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>Carcinoma of St. Bensg with metastases to lung:- 1-2 yrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Sept 1, 1956</b> to <b>Sept 5, 1956</b> that I last saw the deceased alive on <b>Sept 4, 1956</b> , and that death occurred at <b>5:13 AM</b> , from the causes and on the date stated above. ACTUAL SIGNATURE <b>B. M. Schindler M.D.</b> ADDRESS (Street, city or town, state) <b>41 Locust, Cumberland, Maryland</b> DATE SIGNED			
PHYSICIAN'S NAME (Type) <b>DR. B. SCHINDLER</b>		22b. DATE THEREOF <b>9/7/56</b>	
22c. NAME OF CEMETERY OR CREMATORIUM <b>Rose Hill Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Cumberland, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>H. Wayne George</b>		ADDRESS <b>Cumberland, Md.</b>	
24a. REC'D BY REGISTRAR <b>Sept 7, 1956</b>		24b. REGISTRAR'S SIGNATURE <b>W. Frank, M.D.</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4  
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

GENERAL STATE GOVERNMENT OF HAWAII - DEPARTMENT OF

CERTIFICATE OF DEATH

NAME OF DECEASED	AGE	SEX	CAUSE OF DEATH	DEATH CERTIFIED
WILLIAM J. KELLY	50	Male	Heart Disease	Yes
ADDRESS	AGE AT DEATH	TIME OF DEATH	DEATH CERTIFIED	DEATH CERTIFIED
1215 KAHANAMOKU	50	10:00 P.M.	Yes	Yes
NAME AND ADDRESS OF DOCTOR	NAME AND ADDRESS OF HOSPITAL	NAME AND ADDRESS OF FUNERAL HOME	NAME AND ADDRESS OF CEMETERY	NAME AND ADDRESS OF FUNERAL HOME
DR. RICHARD L. COOPER 1215 KAHANAMOKU	HAWAII STATE HOSPITAL 1215 KAHANAMOKU	NAIKAHANA FUNERAL HOME 1215 KAHANAMOKU	NAIKAHANA CEMETERY 1215 KAHANAMOKU	NAIKAHANA FUNERAL HOME 1215 KAHANAMOKU
NAME OF PERSON SIGNING	POSITION	DATE	TIME	DATE
WILLIAM J. KELLY	Deceased	SEP 10 1956	10:00 P.M.	SEP 10 1956

BUREAU V. S.

SEP 10 1956

REFILED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08908

Within corporate limits

8899

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH a. COUNTY <b>Allegany</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Allegany</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>		c. LENGTH OF STAY IN lb <b>9/24/54</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Lonaconing, Maryland</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Allegany County Infirmary</b>		d. STREET ADDRESS <b>25 Robin Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <b>James</b>	Middle <b>A.</b>	Last <b>Moses</b>	4. DATE OF DEATH <b>September 29, 1956</b>	Month	Day	Year
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6/16/1889</b>	9. AGE (In years last birthday) yrs. <b>67</b>	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired - Restaurant Worker</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Lonaconing, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Jacob Moses</b>		14. MOTHER'S MAIDEN NAME <b>Annie Johnson</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Allegany County Infirmary Records</b>		Address P.O. Box 599	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		<i>Coronary Thrombosis</i>				INTERVAL BETWEEN ONSET AND DEATH <b>9/27/56</b> To <b>9/29/56</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m.      p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>49 Greene St.</b>		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>9/24/54</b> , 19____, to <b>9/29/56</b> , 19____, that I last saw the deceased alive on <b>9/29/56</b> , 19____, and that death occurred at <b>1:55 P.M.</b> , from the causes and on the date stated above.				ADDRESS (Street, city or town, state) <b>Cumberland, Md.</b>		DATE SIGNED <b>10/1/56</b>	
ACTUAL SIGNATURE <b>B. Blawieker</b>							
PHYSICIAN'S NAME (Type) <b>Dr. L. B. Mathews</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>10/2/56</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Laurel Hill Cemetery</b>		22d. LOCATION (City, town, or county) <b>MOSCOW, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>George Eichhorn</b>		ADDRESS <b>Lonaconing, Md.</b>		24a. REC'D BY REGISTRAR <b>Oct 2, 1956</b>		24b. REGISTRAR'S SIGNATURE <b>W. F. Gratz, M.D.</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

OCT 3 1956

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8936

## CERTIFICATE OF DEATH

08909  
Reg. Dist. No. 9

1. PLACE OF DEATH a. COUNTY <b>Allegany</b>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>MARYLAND</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frostburg</b>		c. LENGTH OF STAY IN lb <b>1 wk.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Miners Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <b>JOHN</b>	Middle <b>MUIR</b>	4. DATE OF DEATH Month <b>Sept.</b> Day <b>4,</b> Year <b>19 56</b>
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5-21-1877</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>retired trucker</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Kelly-Spgfd. Co.</b>	11. BIRTHPLACE (State or foreign country) <b>Maryland</b>
13. FATHER'S NAME <b>Michael Muir</b>		14. MOTHER'S MAIDEN NAME <b>Janet Tilford</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>214-05-9925A</b>	17. INFORMANT Address <b>Mrs. Mary Muir, Eckhart, Md.</b>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>422.1</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c)		INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b>	
DUE TO  (b) DUE TO (c)		arteriosclerotic Cardio-vascular disease, glas.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED White of work <input type="checkbox"/> Not white of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>March, 1950</b> to <b>Sept 4, 1956</b> , that I last saw the deceased alive on <b>Sept. 4, 1956</b> , and that death occurred at <b>Frostburg</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>John B. Davis, M.D.</b>		ADDRESS (Street, city or town, state) <b>Frostburg, Md.</b> DATE SIGNED <b>9/6/56</b>	
PHYSICIAN'S NAME (Type) <b>John B. Davis, M.D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>9-7-1956</b>	22c. NAME OF CEMETERY OR CREMATORIUM <b>Eckhart Cemetery</b>
22d. LOCATION (City, town, or county) <b>Eckhart, Md.</b>		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>J. R. Durst, Frostburg, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>9-7-56</b>	24b. REGISTRAR'S SIGNATURE <b>Mrs. Nancy H. Lee</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MANHATTAN STATE DEPARTMENT OF HEALTH - SANITATION  
CERTIFICATE OF DEATH

DEATH

NAME  
ADDRESS  
CITY STATE ZIP

BUREAU V. S.

CC 10 1956

KIEGEV E D

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 24 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08910

DR. R.J. WILLIAMS

8300

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b>		b. COUNTY <b>ALLEGANY</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>		c. LENGTH OF STAY IN 1b <b>3 DAYS</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>		d. STREET ADDRESS <b>SOUTHERN HOTEL, N. MECHANIC ST.</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MEMORIAL HOSPITAL</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)		First <b>WILLIAM</b>	Middle <b>M.</b>	Last <b>MURPHY</b>	4. DATE OF DEATH	Month <b>SEPTEMBER</b>	Day <b>4</b>	Year <b>1956</b>
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>9/8/1887</b>	9. AGE (In years last birthday) <b>68 yrs X 1/2 yrs.</b>	IF UNDER 1 YEAR Months <b>0</b>	IF UNDER 24 HRS. Days <b>0</b>	Hours <b>0</b>	Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Carpenter</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Construction Work</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>PATRICK MURPHY</b>		14. MOTHER'S MAIDEN NAME <b>ELIZABETH DONAHUE</b>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>YES</b>		16. SOCIAL SECURITY NO. <b>320-10-9385</b>		17. INFORMANT <b>MEMORIAL HOSPITAL-MEMORIAL &amp; WARWICK AVENUES</b>		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1</b>		DUE TO <b>Coronary Thrombosis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 hr</b>				
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO <b>Coronary Artery Disease</b>		(c)		-		-		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour a. m. p. m. <b>19</b>		Month, Day, Year <b>9/1/56</b>	20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>9/1/56</b>	20f. (City or town) <b>Cumberland</b>	(County) <b>Md</b>	(State) <b>Md</b>	
21. I certify that I attended the deceased from alive on <b>9/3/56</b> , 19 <b>56</b> , to <b>9/4/56</b> , 19 <b>56</b> , and that death occurred at <b>2:15A M</b> , from the causes and on the date stated above.				ADDRESS (Street, city or town, state) <b>Cumberland, Md</b>		DATE SIGNED <b>9/4/56</b>		
ACTUAL SIGNATURE <b>R.J. Williams</b>		PHYSICIAN'S NAME (Type) <b>DR. R. J. WILLIAMS</b>						
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Sept 6 1956</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>St. Peter &amp; Paul Cem.</b>		22d. LOCATION (City, town, or county) <b>Cumb. Md</b>		(State) <b>Md</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Lewis Stein Inc</b>		ADDRESS <b>Cumb. Md</b>		24a. REC'D/BY REGISTRAR DATE <b>Sept. 5, 1956</b>		24b. REGISTRAR'S SIGNATURE <b>W. Frank, M.D.</b>		

CERTIFICATE OF DEATH

BUREAU V. S.

SEP 6 1956

RECEIVED

## Within corporate limits MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08911

DR. W.F.WMS..

8901

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE WEST VIRGINIA b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 4 DAYS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL-MEMORIAL AVE.		e. STREET ADDRESS 59 ORCHARD ST.	
3. NAME OF DECEASED (Type or print) GUSTAVUS		First B	Middle NAEDELE
4. DATE OF DEATH Month SEPTEMBER Day 25 Year 1956			
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> AUGUST 12, 1891
9. AGE (In years lost birthday) 65 yrs.		10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Jeweler		10b. KIND OF BUSINESS OR INDUSTRY Own business	
11. BIRTHPLACE (State or foreign country) W.VA		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME ERNEST NAEDELE		14. MOTHER'S MAIDEN NAME SARAH FRY	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. R33-50-3789	17. INFORMANT MEMORIAL HOSPITAL Address CUMBERLAND, MD.
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)  163 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) <i>Carcinoma left lung from March '56</i> <i>Left lung removed Wash. DC April '56.</i>			
INTERVAL BETWEEN ONSET AND DEATH <i>March '56</i>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 9-21-1956, to 9-25-1956, that I last saw the deceased alive on 9-25-1956, and that death occurred at 8:20P.M. from the causes and on the date stated above. ACTUAL SIGNATURE <i>W. F. Williams</i> M.D. ADDRESS (Street, city or town, state) Physician's Name (Type) W. F. Williams Cumberland, Md. DATE SIGNED 9-26-56			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 9-28-56	22c. NAME OF CEMETERY OR CREMATORIUM Lahmansville Cemetery	22d. LOCATION (City, town, or county) (State) Lahmansville, W. Va.
23. FUNERAL DIRECTOR'S SIGNATURE J. H. Markwood		ADDRESS Keyser, W. Va.	24a. REC'D BY REGISTRAR DATE Sept 28 1956
			24b. REGISTRAR'S SIGNATURE <i>W. R. Franta, M.D.</i>

RECEIVED

FEDERAL BUREAU OF INVESTIGATION

OCT 1 1956

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08912

Reg. Dist. No. 4

8902

## CERTIFICATE OF DEATH

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death; page 4 may be retained by the hospital or attending physician and completely filled in by funeral director.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b>		b. COUNTY <b>ALLEGANY</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>		c. LENGTH OF STAY IN 1b <b>3 DAYS</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>		d. STREET ADDRESS <b>608 MONTGOMERY AVE.</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MEMORIAL HOSPITAL</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <b>MR. WILLIAM DAVID NEWBERREY</b>		First <b>WILLIAM</b>	Middle <b>DAVID</b>	Last <b>NEWBERREY</b>	4. DATE OF DEATH <b>SEPT. 2</b>	Month <b>SEPT.</b>	Day <b>2</b>	Year <b>1956</b>
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	B. DATE OF BIRTH <b>JAN. 21 1889</b>	9. AGE (In years lost birthday) <b>67</b> yrs.	IF UNDER 1 YEAR Months <b>0</b>	IF UNDER 24 HRS. Days <b>0</b>	Hours <b>0</b>	Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>ENGINEER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>HOSPITAL</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>XANTOKEE NEWBERREY</b>		14. MOTHER'S MAIDEN NAME <b>HENRETTA SMALL</b>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>214-07-0637</b>		17. INFORMANT <b>MEMORIAL HOSPITAL, CUMBERLAND, MD.</b>		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arterio sclerotic cardio</b> INTERVAL BETWEEN ONSET AND DEATH 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) <b>Vascular disease</b> DUE TO (c) <b>Benign hypertrophy prostate</b>								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour o. m. p. m. 19		Month 19	Day	20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <b>9-2-1953</b> to <b>9-2-1956</b> , that I last saw the deceased alive on <b>9-2-1956</b> , and that death occurred at <b>10:15 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Wm. F. Williams, Cumberland, Md.</b> DATE SIGNED <b>9-3-56</b>								
ACTUAL SIGNATURE								
PHYSICIAN'S NAME (Type)								
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Sept. 5, 1956</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Louden Park Cemetery</b>		22d. LOCATION (City, town, or county) <b>Baltimore, Md.</b> (State)		
23. FUNERAL DIRECTOR'S SIGNATURE <b>Charles L. George, Cumberland, Md.</b> ADDRESS REC'D BY REGISTRAR <b>Sept. 5, 1956</b> 24b. REGISTRAR'S SIGNATURE <b>W.L. Fenty, M.D.</b>								



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08913

## 8951 CERTIFICATE OF DEATH

Reg. Dist. No. 4

## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death.

The bottom copy may be retained by the hospital or attending physician.  
**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

<b>1. PLACE OF DEATH</b>		<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>	
COUNTY CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN	MARYLAND LENGTH OF STAY (in this place)	STATE CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN	COUNTY Allegany (If rural give location)
HOSPITAL OR INSTITUTION OR STREET ADDRESS  X 00		STREET ADDRESS  Cresaptown	
<b>3. NAME OF DECEASED</b> (First) Howard (Middle) Poland (Last)		<b>4. DATE OF DEATH</b> Sept 15 1956	
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed	8. DATE OF BIRTH May 1, 1868
9. AGE last birthday 88 yrs.	10. KIND OF BUSINESS OR INDUSTRY W.Va.P & P Co	11. BIRTHPLACE (State or foreign country) Barton, Md	12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME Frederick Poland	14. MOTHER'S MAIDEN NAME Eva Howell	15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) no	
16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS Mrs. Acye Poland, Cresaptown Md	
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>			
442X IMMEDIATE CAUSE (A) <u>Appoplectic stroke.</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Cardio - renal vascular disease</u>			
DISEASES OR CONDITIONS, IF ANY, (B) GIVING RISE TO THE ABOVE CAUSE, DUE TO (C) STATING UNDERLYING CAUSE LAST. <u>Sensility</u>			
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>			
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		
21c. WHERE DID INJURY OCCUR? (City or town)  County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?	
M.			
<b>22. I hereby certify that I attended the deceased from Aug. 29, 1956, to Sept. 15, 1956, that I last saw the deceased alive on Sept. 15, 1956, and that death occurred at 9 P.M., from the causes and on the date stated above. 9-18-56</b>			
<b>SIGNATURE</b> <u>Lyle R. Everett</u> <b>ADDRESS</b> (Street, city, town, state) <u>36 Greene St Cumberland Md</u> <b>DATE SIGNED</b> <u>9-18-56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	DATE THEREOF Sept 18/56	NAME OF CEMETERY OR CREMATORIUM Philos Cem.	LOCATION (City, town, or county) Westernport, Md. (State)
24. REC'D BY REGISTRAR Sept. 21, 1956	REGISTRAR'S SIGNATURE W.L. Gantz, M.D.	25. FUNERAL DIRECTOR'S SIGNATURE W. Howell Frederik Piedmont, W.Va.	

61860

BY THE SECRETARY OF STATE OF CALIFORNIA

STATE OF CALIFORNIA

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OF STATE

REG. NO.

1956-1957

REG. NO.

REG. NO.

REG. NO.

REG. NO.

BUREAU

FEDERAL BUREAU OF INVESTIGATION

SEP 24 1956

RECEIVED

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

108914  
6

Reg. Dist. No.

8952

1. PLACE OF DEATH a. COUNTY <b>Allegany</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>M d.</b> b. COUNTY <b>Allegany</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Westernport</b>		c. LENGTH OF STAY IN lb <b>50 yrs.</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Brasher St. near road</b>		e. IS RESIDENCE / ON A FARM? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)	First <b>Claude</b>	Middle <b>Wilson</b>	Last <b>Riggleman</b>	
4. DATE OF DEATH	Month <b>Sept.</b>	Day <b>11</b>	Year <b>1956</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 15-1889</b>	
9. AGE (In years last birthday) <b>67 yr.</b>	10. IF UNDER 1 YEAR Months <b>0</b>	11. IF UNDER 24 HRS. Days <b>0</b>	Hours <b>0</b>	Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Truck driver for the-Town of Westernport, Md.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Petersburg, W.Va.</b>		
10c. BIRTHPLACE (State or foreign country) <b>Port, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>William Riggleman</b>		14. MOTHER'S MAIDEN NAME		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <b>218-10-3250</b> (wife) Alice T. Riggleman, Franklin, Md.		
17. INFORMANT		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH		
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1</b>		Coronary occlusion		
DUE TO { Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)		Coronary sclerosis		
DUE TO (c)				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) <b>(County)</b>				(State) <b>(State)</b>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .				
ACTUAL SIGNATURE <i>H. V. Deming M.D.</i>	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			DATE SIGNED
EXAMINER'S NAME (Type) <b>H. V. Deming M.D.</b>	ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>9/14/56</b>	22c. NAME OF CEMETERY OR CREMATORIAL <b>Dubois Cem.</b>	22d. LOCATION (City, town, or county) <b>Mineral Ct. W-V</b>	(State) <b>(State)</b>
23. FUNERAL DIRECTOR'S SIGNATURE <i>E. Oval</i>	ADDRESS <b>Brasher St. near road</b>	24a. REC'D BY REGISTRAR <b>9-12-56</b>	24b. REGISTRAR'S SIGNATURE <b>Jan C Kelly</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending," in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MANUFACTURER'S STATEMENT OF HAZARD-DEFINITION TO  
Hazardous Substances Classification

BUREAU V.

SEP 14 1956

REGISTRY

Within corporate limits

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

18915

DR. BALLIN

8903

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b>		b. COUNTY <b>ALLEGANY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>		c. LENGTH OF STAY IN 1b <b>5 HR. 30 MIN.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MEMORIAL HOSPITAL</b>		d. STREET ADDRESS <b>123 POLK ST.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <b>RALPH</b>	Middle <b>L</b>	Last <b>RIZER</b>	4. DATE OF DEATH <b>SEPT. 15, 1956</b>	Month <b>SEPT.</b>	Day <b>15,</b>	Year <b>1956</b>
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <b>JUNE 23, 1884</b>	9. AGE (In years lost birthday) <b>72 yrs.</b>	IF UNDER 1 YEAR Months <b>0</b>	IF UNDER 24 HRS. Days <b>0</b>	Hours <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Engineer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Civil</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>CHARLES RIZER</b>		14. MOTHER'S MAIDEN NAME <b>AMANDA BUTTS</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>	16. SOCIAL SECURITY NO. <b>None</b>	17. INFORMANT <b>MEMORIAL HOSPITAL-WARWICK &amp; MEMORIAL AVES.</b>	Address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Heart Disease</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>420.1</b> (b) DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <b>1 year</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Diabetes mellitus (16 years) Fibromyositis (5 years)</b> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. p. m.	Month 19	Day	Year	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <b>9-25, 1954</b> , to <b>9-15, 1956</b> , that I last saw the deceased alive on <b>9-15, 1956</b> , and that death occurred at <b>5:30 P.M.</b> from the causes and on the date stated above. ACTUAL SIGNATURE <b>Ralph W. Ballin</b> ADDRESS (Street, city or town, state) <b>62 Greene St. Cumberland, Md.</b> DATE SIGNED <b>9-16-56</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>9-18-1956</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Rose Hill Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Cumberland, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Charles L. George</b>		ADDRESS <b>Cumberland, Md.</b>		24a. REC'D BY REGISTRAR <b>17. 1956</b>		24b. REGISTRAR'S SIGNATURE <b>W.L. Frantz, M.D.</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED  
FEDERAL BUREAU OF INVESTIGATION  
U.S. DEPARTMENT OF JUSTICE

150 BIRK ST.

ATLANTA, GA 30303

BUREAU V.

SEP 19 1956

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08916

Within corporate limits

8904

## CERTIFICATE OF DEATH

Reg. Dist. No.

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b>		b. COUNTY <b>ALLEGANY</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>		c. LENGTH OF STAY IN 1b <b>5 DAYS</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>		d. STREET ADDRESS <b>217 GLENN STREET</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MEMORIAL HOSPITAL MEMORIAL &amp; WARWICK AVES.,</b>				d. STREET ADDRESS <b>217 GLENN STREET</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First <b>ETHEL</b>	Middle <b>B.</b>	Last <b>SCHELL</b>	4. DATE OF DEATH	Month <b>SEPTEMBER</b>	Day <b>17</b>	Year <b>1956</b>	
S. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>FEBRUARY 14, 1908</b>		9. AGE (In years last birthday) <b>48 yrs.</b>	IF UNDER 1 YEAR Months <b>0</b>	IF UNDER 24 HRS. Days <b>0</b>	Hours <b>0</b>	Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (State or foreign country) <b>W.VA. Keyser</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>EZRA BOSLEY</b>				14. MOTHER'S MAIDEN NAME <b>MAMIE REICHENBACH</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>215-20-5152</b>		17. INFORMANT <b>Wm. G. Schell, Cumberland, Maryland</b>		217 Glenn Street			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]  PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>443X</b> Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.  DUE TO <b>Hypertension CVD.</b>  (b) DUE TO <b>of Urinary —</b>  (c)						INTERVAL BETWEEN ONSET AND DEATH <b>0 days</b>			
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  <b>—</b>							
20c. TIME OF INJURY Hour a. m. p. m. <b>— 19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>—</b>		20f. (City or town) <b>—</b>		(County) <b>—</b>	(State) <b>—</b>
21. I certify that I attended the deceased from <b>10/11/56</b> , 19, to <b>9/17/56</b> , 19, that I last saw the deceased alive on <b>9/17/56</b> , 19, and that death occurred at <b>10:32 AM</b> , from the causes and on the date stated above.						ADDRESS (Street, city or town, state) <b>Cumberland</b>		DATE SIGNED <b>9/18/56</b>	
ACTUAL SIGNATURE  <b>R. J. Williams</b>									
PHYSICIAN'S NAME (Type) <b>RICHARD J. WILLIAMS</b>									
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>9/20/56</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Rose Hill Cemetery</b>		22d. LOCATION (City, town, or county) <b>Cumberland, Maryland</b>		(State) <b>—</b>	
23. FUNERAL DIRECTOR'S SIGNATURE  <b>John J. Hafer, Cumberland, Maryland</b>		ADDRESS  <b>—</b>		24a. REC'D. BY REGISTRAR <b>Sept. 19, 1956</b>		24b. REGISTRAR'S SIGNATURE <b>W. F. Gantz, M.D.</b>			

THE STATE GOVERNMENT OF HERTZOG—MARCH 19

BUREAU A. S.

SEP 21 1956

ΚΕΓΕΙΛΥ ΕΩ

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4  
 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit Permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 24 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18												CERTIFICATE OF DEATH		Reg. Dist. No. 08917	
<b>Outside of City Limits</b>		8953													
1. PLACE OF DEATH a. COUNTY <b>Allegany</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Allegany</b>											
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>LaVale</b>				c. LENGTH OF STAY IN lb <b>1b</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>LaVale</b>							
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS								e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Eliza Nancy</b>		First <b></b>		Middle <b>Schramm</b>		Last <b></b>		4. DATE OF DEATH <b>Sept 27</b>		Month <b>Sept</b>		Day <b>27</b>		Year <b>1956</b>	
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Nov. 17, 1875</b>		9. AGE (In years last birthday) <b>80</b> yrs. Months <b>0</b> Days <b>0</b>		IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b>		IF UNDER 24 HRS. Hours <b>0</b> Min. <b>0</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House wife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Own home</b>				11. BIRTHPLACE (State or foreign country) <b>Barton, Md.</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>Franklin Pearce</b>						14. MOTHER'S MAIDEN NAME <b>Susan Michael</b>						Address			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO. <b>None</b>				17. INFORMANT <b>William Schramm</b>				INTERVAL BETWEEN ONSET AND DEATH <b>From 9-18-54</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cancer</b> <b>151X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)															
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Resection of stomach 9-18-54</b>												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>9-13-54 to 9-27-54</b>											
20c. TIME OF INJURY Hour o. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Moscow</b>		20f. (City or town) (County) <b>Moscow</b> (State)									
21. I certify that I attended the deceased from <b>9-13-54</b> to <b>9-27-54</b> , that I last saw the deceased alive on <b>9-25-54</b> , and that death occurred at <b>Moscow</b> , from the causes and on the date stated above. ACTUAL SIGNATURE <b>W. F. Williams</b> PHYSICIAN'S NAME (Type) <b>W. F. Williams</b>												ADDRESS (Street, city or town, state) <b>Moscow, Md.</b> DATE SIGNED <b>9-29-56</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>9/30/56</b>		22c. NAME OF CEMETERY OR CREMATORIAL <b>Laurel Hill</b>				22d. LOCATION (City, town, or county) <b>Moscow</b> (State)							
23. FUNERAL DIRECTOR'S SIGNATURE <b>G. Boal</b>												ADDRESS <b>Westernport, Md.</b>			
												24a. REC'D BY REGISTRAR DATE <b>Oct. 1, 1956</b>		24b. REGISTRAR'S SIGNATURE <b>J. R. Tracy, M.D.</b>	

**BUREAU V. S.**

OCT 3 1956

**REGELIV ED**

8905

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b>		b. COUNTY <b>ALLEGANY</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>		c. LENGTH OF STAY IN 1b <b>14 DAYS</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MEMORIAL HOSPITAL MEMORIAL &amp; WARWICK AVES</b>				d. STREET ADDRESS <b>117 ARCH STREET</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <b>FRANK</b>		First <b>J.</b>	Middle <b>SCHRIEVER</b>	Last <b>SCHRIEVER</b>	4. DATE OF DEATH <b>AUG. 26</b>	Month <b>SEPTEMBER</b>	Day <b>17</b>	Year <b>1956</b>
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>AUG. 26</b>	9. AGE (In years lost birthday) <b>77</b> yrs.	IF UNDER 1 YEAR Months <b>0</b>	IF UNDER 24 HRS. Hours <b>0</b>	Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Textile Worker</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Silk Industry</b>		11. BIRTHPLACE (State or foreign country) <b>PENNA-Buck Valley</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
13. FATHER'S NAME <b>GEORGE SCHRIEVER</b>		14. MOTHER'S MAIDEN NAME <b>Jennie ?</b>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>217-10-5412</b>		17. INFORMANT <b>Mrs. Clara Schriver, Cumberland, Md.</b>		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Coronary Occlusion</b>		DUE TO <b>420.1</b>		INTERVAL BETWEEN ONSET AND DEATH <b>minutes</b>				
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) Coronary Sclerosis		DUE TO <b>420.1</b>		years				
(c) <b>Arteriosclerosis</b>								
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour o. m. p. m. 19		Month July	Day 19	Year 56	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) M.D. 133 Virginia Ave, Cumberland, Md.	20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19_____, to _____, 19_____, that I last saw the deceased alive on _____, 19_____, and that death occurred at 8:15 AM from the causes and on the date stated above. ACTUAL SIGNATURE <i>G. Overton Himmelwright, M.D.</i>				ADDRESS (Street, city or town, state) <i>133 Virginia Ave, Cumberland, Md.</i>		DATE SIGNED <i>9/17/56</i>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>9-20-56</b>	22c. NAME OF CEMETERY OR CREMATORIUM <b>Davis Memorial</b>		22d. LOCATION (City, town, or county) <b>Cumberland, Md.</b>		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>James F. Scarbelli, Cumberland, Md.</b>		ADDRESS		24a. REC'D BY REGISTRAR <b>Sept. 20, 1956</b>		24b. REGISTRAR'S SIGNATURE <b>W.R. Frantz, M.D.</b>		

STATE OF CALIFORNIA  
DEPARTMENT OF HEALTH - SAN FRANCISCO

CERTIFICATE OF DEATH

BUREAU V. S.

SEP 24 1956

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 Film G204 9-20-56 et

08919

## CERTIFICATE OF DEATH

Reg. Dist. No.

Within corporate limits  
Item 8: G204 9-25-56 L

8946

1. PLACE OF DEATH  
a. COUNTY

Allegany

MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)  
a. STATE

Maryland

b. COUNTY

Allegany

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Cumberland

c. LENGTH OF STAY IN 1b

28 days

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Cumberland

d. NAME OF HOSPITAL (If not in hospital, give street address)  
OR INSTITUTION

Sacred Heart Hospital

d. STREET ADDRESS

315 Oldtown Road

e. IS RESIDENCE  
ON A FARM?YES  NO 3. NAME OF  
DECEASED  
(Type or print)First  
JacobMiddle  
C.Last  
Schroder4. DATE  
OF  
DEATHMonth  
SeptemberDay  
8Year  
1956

5. SEX

Male

6. COLOR OR RACE

White

7. MARRIED  NEVER MARRIED WIDOWED DIVORCED 

B. DATE OF BIRTH

12/2/1883

9. AGE (In years  
last birthday)

72 78

IF UNDER 1 YEAR

Months

IF UNDER 24 HRS.

Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work done  
during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF WHAT COUNTRY?

Engineer

Retired

B.&amp;O. Railroad

W. Va. Sleepy Creek

U.S.A.

13. FATHER'S NAME

Herman Schroder

14. MOTHER'S MAIDEN NAME

Freida Kimmerling

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no, or unknown)

(If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

17. INFORMANT

Address

705-T2-5773

Patient's Chart.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a)

Metastatic brain tumor

INTERVAL BETWEEN  
ONSET AND DEATH

3 month

145X

DUE TO

Conditions, if any, which  
gave rise to immediate  
cause (a), stating the under-  
lying cause last.

DUE TO

(b)

Squamous cell carcinoma / left tonsil

6 month

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY  
PERFORMED?YES  NO 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING  CAUSE OF DEATH  
(If either, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year

Hour o. m.  
p. m.

19

at work

White  Nat white   
at work  of work 

20d. INJURY OCCURRED

White  Nat white   
at work  of work 20e. PLACE OF INJURY (Home, farm,  
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I attended the deceased from August 24, 1956 to Sept. 8, 1956, that I last saw the deceased  
alive on Sept. 8, 1956, and that death occurred at 2:15 P.M. from the causes and on the date stated above.

ADDRESS (Street, city or town, state)

DATE SIGNED

ACTUAL  
SIGNATURE

L Brings

M.D.

51 Green St. Cumberland Md 9-8-56

PHYSICIAN'S  
NAME (Type)

LEWIS BRINGS

22a. BURIAL, CREMATION,  
REMOVAL (Specify)

Burial

22b. DATE THEREOF

9-11-56

22c. NAME OF CEMETERY OR CREMATORIUM

Rose Hill Cem.

22d. LOCATION (City, town, or county)

Cumberland Md.

(State)

23. FUNERAL DIRECTOR'S SIGNATURE

James F. Scarpelli Cumberland, Md.

ADDRESS

24a. REC'D BY REGISTRAR

Sept. 8, 1956

DATE

24b. REGISTRAR'S SIGNATURE

W.H. Frank, M.D.

CEASER STATE OF BOSTON

BUREAU V. S.  
RECEIVED  
SEP 13 1956

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 7 Film G204 10-5-56 et

08920

Within corporate limits

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		8907 Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 30 yrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland, Md.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 721 Montgomery Ave.		d. STREET ADDRESS 721 Montgomery Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Walter W. Seel		First	Middle	Last	4. DATE OF DEATH Sept. 26, 1956
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH Dec. 24, 1889	9. AGE (In years lost birthday) 66 yrs.	IF UNDER 1 YEAR Months Days Hours Min. 00 00 00 00
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Flagman		10b. KIND OF BUSINESS OR INDUSTRY Railroad		11. BIRTHPLACE (State or foreign country) Pittsburg, Pa.	
13. FATHER'S NAME John Seel		14. MOTHER'S MAIDEN NAME Amelia ?		12. CITIZEN OF WHAT COUNTRY? USA	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 705-09-4156		17. INFORMANT Hazel Seel 721 Montgomery Ave Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]  PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)		Coronary Thrombosis Coronary Artery Disease		INTERVAL BETWEEN ONSET AND DEATH Sudden	
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20d. INJURY OCCURRED White Nat while at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>9-5-56</u> , 19 <u>56</u> , to <u>9-26-56</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>9-19-56</u> , 19 <u>56</u> , and that death occurred at <u>6:30A.M.</u> from the causes and on the date stated above. ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) Richard J. Williams		ADDRESS Hillcrest Burial Park Cumberland, Md.		ADDRESS (Street, city or town, state) DATE SIGNED 9-27-56	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-29-56		22c. NAME OF CEMETERY OR CREMATORIAL Hillcrest Burial Park	
22d. LOCATION (City, town, or county) Cumberland, Md.				(State)	
23. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli		ADDRESS Cumberland, Md.		24a. REC'D BY REGISTRAR DATE Sept. 28, 1956	
				24b. REGISTRAR'S SIGNATURE W. R. Thaxter, M.D.	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF CALIFORNIA  
DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

RECEIVED

BUREAU U. S.

OCT 1 1956

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "Pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										08921	
MEDICAL EXAMINER'S CERTIFICATE OF DEATH										Reg. Dist. No. 4	
1. PLACE OF DEATH a. COUNTY      Allegany      MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE      Md.      b. COUNTY      Allegany						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland			c. LENGTH OF STAY IN 1b 3 yrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland						
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 1010 Ella Ave.					d. STREET ADDRESS 1010 Ella Ave.					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First Janice	Middle Louise	Last Senn	4. DATE OF DEATH Sept. 28 1956						
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 6-1953		9. AGE (In years last birthday) 3 yrs.		IF UNDER 1YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country) Cumberland, Md.			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Robert Norman Senn					14. MOTHER'S MAIDEN NAME Doris Stonebraker					Address	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no					16. SOCIAL SECURITY NO. none					17. INFORMANT (father) R.N. Senn, Cumberland, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]										INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)      Erythema multiforme      1 yr. DUE TO 490X      Adrenal failure										1 yr.	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b)      Adrenal failure											
DUE TO (c)      Lobar pneumonia (left)											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour      a. m.      p. m.		Month, Day, Year 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/>											
ACTUAL SIGNATURE <u>H.V. Deming M.D.</u>										DATE SIGNED	
EXAMINER'S NAME (Type)      H.V. Deming M.D.										M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Sept. 28-1956	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Sept. 30, 1956		22c. NAME OF CEMETERY OR CREMATORIUM Davis Memorial Cemetery		22d. LOCATION (City, town, or county) Cumberland, Md.		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE Charles L. George, Cumberland, Md.										ADDRESS George	
24a. REC'D BY REGISTRAR Oct. 1, 1956										24b. REGISTRAR'S SIGNATURE W.R. Tracy, M.D.	

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BUREAU V. S.

OCT 3 1956

REGELY ED

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

08922  
9

8954		Reg. Dist. No.								
1. PLACE OF DEATH a. COUNTY <b>Allegany</b>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Md.</b>								
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Eckhart Mines</b>		b. COUNTY <b>Allegany</b>								
c. LENGTH OF STAY IN lb <b>81</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Eckhart Mines, Parkersburg Road</b>								
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>R.F.D.#2 Frostburg, Md.</b>		d. STREET ADDRESS <b>R.F.D.#2 Frostburg, Md.</b>								
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										
3. NAME OF DECEASED (Type or print) <b>Anna</b>		First <b>Anna</b>	Middle <b>Martha</b>	Last <b>Shanholtz</b>	4. DATE OF DEATH <b>Sept. 1 1956</b>	Month <b>Sept.</b>	Day <b>1</b>	Year <b>56</b>		
5. SEX <b>Female</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Feb. 9-1875</b>		9. AGE (In years last birthday) <b>81</b> yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Eckhart Mines, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				
13. FATHER'S NAME <b>William Dudley</b>		14. MOTHER'S MAIDEN NAME <b>Elizabeth Lemmert</b>								
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT <b>(nephew) Wm. Dudley, Eckhart, Md.</b>		Address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]										
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Generalized arteriosclerosis.</b> INTERVAL BETWEEN ONSET AND DEATH ?										
450.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b)										
DUE TO (c)										
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Hour o. m. p. m.		Month, Day, Year <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>Eckhart</b>		(County) <b>Allegany</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .										
ACTUAL SIGNATURE <i>H.V. Deming M.D.</i>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED <b>Sept. 1-1956</b>		
EXAMINER'S NAME (Type) <b>H.V. Deming M.D.</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>						
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>9-4-56</b>		22c. NAME OF CEMETERY OR CREMATORIAL <b>Eckhart</b>		22d. LOCATION (City, town, or county) <b>Eckhart, Md.</b>		(State)		
23. FUNERAL DIRECTOR'S SIGNATURE <i>Joseph R. Durst - Frostburg</i>		ADDRESS <b>Frostburg</b>		24a. REC'D BY REGISTRAR <b>9-4-56</b>		24b. REGISTRAR'S SIGNATURE <i>Mr. Dailey N. Rose</i>				

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.  
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

WISCONSIN STATE EXAMINER'S CERTIFICATE OF DEATH

RECEIVED  
BUREAU V. S.  
SEP 10 1956  
REFEEIVED

**INSTRUCTIONS**

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10A

**MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18**

08923

**Within corporate limits CERTIFICATE OF DEATH**  
 8909

Reg. Dist. No. 7

<b>1. PLACE OF DEATH</b>		<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>	
COUNTY CITY TOWN	<b>Allegany</b> <b>MARYLAND</b> <b>Cumberland</b>	STATE CITY TOWN	<b>Maryland</b> <b>Allegany</b> <b>Cumberland</b>
HOSPITAL OR INSTITUTION OR STREET ADDRESS	<b>Sylvan Retreat</b> <b>Furnace St.</b>	STREET ADDRESS	<b>221 Harrison St.</b> <small>(If rural give location)</small>
<b>3. NAME OF DECEASED</b> (Type or Print)		<b>4. DATE OF DEATH</b>	
(First) <b>Amos Eugene Shaw</b>		(Middle)	(Last)
S. SEX <b>M.</b>	6. COLOR OR RACE <b>W.</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <b>W.</b>	8. DATE OF BIRTH <b>Oct. 17, 1880</b>
9. AGE last birthday <b>75</b> yrs.		10. KIND OF BUSINESS OR INDUSTRY <b>Railroad</b>	11. BIRTHPLACE (State or foreign country) <b>Maryland</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Issac Shaw</b>	
14. MOTHER'S MAIDEN NAME <b>Mary Rice</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <b>No</b>	
16. SOCIAL SECURITY NO. <b>705-09-2600</b>		17. INFORMANT & ADDRESS <b>Robert Shaw 221 Harrison St.</b>	
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>			
IMMEDIATE CAUSE <b>Pulmonary Congestion</b> ANTECEDENT CAUSE(S) DUE TO <b>Chronic Myocarditis</b> DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO <b>Chronic Nephritis</b> <b>Senile psychosis</b>			
INTERVAL BETWEEN ONSET AND DEATH <b>24 hrs.</b>			
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>			
<b>19. MEDICAL CERTIFICATION</b>			
DATE OF OPERATION <b>19b. MAJOR FINDINGS OF OPERATION</b>			
ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
PLACE (Home, farm, factory, street, office bldg., etc.)			
WHERE DID INJURY OCCUR? (City or town) (County) (State)			
TIME OF INJURY (Month) (Day) (Year) (Hour)		INJURY OCCURRED While at work      Not while at work	
HOW DID INJURY OCCUR?			
<b>22. I hereby certify that I attended the deceased from <b>Sept. 1, 1956</b>, to <b>Sept. 1, 1956</b>, that I last saw the deceased alive on <b>Aug. 31, 1956</b>, and that death occurred at <b>8:45 P.M.</b> from the causes and on the date stated above.</b>			
SIGNATURE <b>Albert E. McLean M.D.</b>		ADDRESS (Street, city, town, state) <b>49 Greene St. 9-1056.</b>	
DATE SIGNED			
BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		DATE THEREOF <b>9-4-56</b>	NAME OF CEMETERY OR CREMATORIUM <b>Hillcrest Burial PARK</b>
REG'D BY REGISTRAR <b>Sept. 4, 1956</b>		REGISTRAR'S SIGNATURE <b>W. R. Tracy M.D.</b>	LOCATION (City, town, or county) <b>Cumberland Md.</b>
DATE <b>Sept. 4, 1956</b>		25. FUNERAL DIRECTOR'S SIGNATURE <b>Louis Shatz Inc. Cumberland Md.</b>	



**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

08924

**8910**

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Allegany</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Allegany</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>02 Cumberland</b>		c. LENGTH OF STAY IN lb <b>1/2 hr.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Old Town (rural)</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Memorial Hospital</b>			d. STREET ADDRESS <b>R.F.D.#1</b>		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <b>Harry Thomas Shryock</b>		First <b>Harry</b>	Middle <b>Thomas</b>	Last <b>Shryock</b>	4. DATE OF DEATH <b>Sept. 1 1956</b>
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 10-1946</b>	9. AGE (In years last birthday) <b>10 yrs.</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Student</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>—</b>		11. BIRTHPLACE (State or foreign country) <b>Cumberland, Md.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>					
13. FATHER'S NAME <b>Harry Marvin Shryock</b>			14. MOTHER'S MAIDEN NAME <b>Mary Marie McDonald</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>			16. SOCIAL SECURITY NO. <b>none</b>		
17. INFORMANT <b>(father) Harry M. Shryock, Old Town, Md.</b>			Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Intracranial Hemorrhage</b> INTERVAL BETWEEN ONSET AND DEATH <b>35 Min.</b> 8/3 X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>fractured skull also had a fractured left</b> DUE TO (c) <b>Humerous.</b>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.			20b. DECODE INJURY (Type of injury in part I, if any, in part II) <b>Riding west on bicycle back of bread truck, turned out</b>		
20c. TIME OF INJURY Month, Day, Year Hour: <b>5.20 p.m.</b> 1956			20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> of work <input type="checkbox"/> at work <input checked="" type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>9 miles east of Highway 51-Rural-Cumberland, Allegany, Md.</b>		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE <b>H.V. Deming M.D.</b>			M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <b>Sept. 1-1956</b>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Sept 4 1956</b>		22c. NAME OF CEMETERY OR CREMATORIAL <b>Davis Mem. Bur. Park, Cumberland, Md.</b>	
22d. LOCATION (City, town, or county) <b>(State)</b>					
23. FUNERAL DIRECTOR'S SIGNATURE <b>John J. Hoyer-Cumberland, Md.</b>			ADDRESS <b>230 Balti. Ave.</b> REC'D BY REGISTRAR <b>Sept. 5, 1956</b> REGISTRAR'S SIGNATURE <b>W.L. Frantz, M.D.</b>		

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

RECEIVED - FBI - LOS ANGELES  
FEDERAL BUREAU OF INVESTIGATION

BUREAU V. 2

SEP 6 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08925

Reg. Dist. No.

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3X  
**H**  
1.  
rural  
near  
Private  
road about 1/4 mile west of route #36  
00

PLACE OF DEATH  
o. COUNTY

8955

Allegany

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

X Franklin

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)  
about 1/4 mile west of route #36

c. LENGTH OF STAY IN 1b

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)

o. STATE

W.Va.

b. COUNTY

Mineral

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Keyser

85X-3

3. NAME OF  
DECEASED  
(Type or print)

First  
James

Middle  
Mitchell

Last  
Sirbaugh

4. DATE  
OF  
DEATH

Month  
Sept.

Day  
18

Year  
19 56

5. SEX

6. COLOR OR RACE

male

white

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Truck driver for Moran Coal Co.

7. MARRIED

NEVER MARRIED

8. DATE OF BIRTH

Sept. 15-1924

32

9. AGE (In years  
last birthday)

32

yr.s

IF UNDER 1 YEAR

Months

Days

Hours

Min.

e. IS RESIDENCE  
ON A FARM?  
YES  NO

13. FATHER'S NAME

Mitchell Sirbaugh

14. MOTHER'S MAIDEN NAME

Unknown Mabel Lewis

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)

yes

If yes, give war or dates of service)

W.W. 2

16. SOCIAL SECURITY NO.

219-14-6320

17. INFORMANT

Mrs. Dolores Sirbaugh, Baltimore, Md.

Address

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY  
IMMEDIATE CAUSE (a)

835X

Conditions, if any, which  
gave rise to immediate cause  
(a), stating the underlying  
cause last.

Exsanguination due to torn blood vessels in sudden  
pelvis & thighs, also had a torn scrotum and right  
thigh nearly severed, puncture wound in thigh,  
fractured pelvis, nose, right frontal & orbital bone,  
several ribs upper left side of chest & right clavicle  
Truck accident.

INTERVAL BETWEEN  
ONSET AND DEATH

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RECEIVED  
BUREAU V. S.

SEP 24 1956

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

18926

8937

## CERTIFICATE OF DEATH

Reg. Dist. No. 9

1. PLACE OF DEATH a. COUNTY <b>Allegany</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Allegany</b>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frostburg</b>		c. LENGTH OF STAY IN 1b RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frostburg</b>		d. STREET ADDRESS <b>158 W. Mechanic St.</b>				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>158 W. Mechanic</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) <b>SALVATORE</b>		First	Middle	Last	4. DATE OF DEATH ( <b>9th 26 1956</b> )	Month	Day	Year		
5. SEX <b>M</b>		6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH <b>11-24-1886</b>	9. AGE (In years lost birthday) <b>69 yrs.</b>	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Tailor</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own business</b>		11. BIRTHPLACE (State or foreign country) <b>New Orleans, La.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				
13. FATHER'S NAME <b>Salvatore Spalla</b>				14. MOTHER'S MAIDEN NAME <b>Carmela Pacci</b>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs. Mary W. Spalla, Frostburg, Md.		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>arterio sclerotic cardio -</b> DUE TO 4221 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>vascular disease,</b> DUE TO (c) <b>Prostotic hypertrophy.</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			Address <b>158 W. Mechanic St., Frostburg, Md.</b>	
									INTERVAL BETWEEN ONSET AND DEATH <b>4 yrs.</b>	
									<b>5 years.</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>Frostburg, Md.</b>		(County) <b>Frederick Co.</b>	(State) <b>Md.</b>	
21. I certify that I attended the deceased from <b>6-10, 1954</b> , to <b>9-26, 1956</b> , that I last saw the deceased alive on <b>9-25, 1956</b> , and that death occurred at <b>7A.M.</b> from the causes and on the date stated above.									ADDRESS (Street, city or town, state) <b>Frostburg, Md.</b>	DATE SIGNED <b>9/27/56</b>
ACTUAL SIGNATURE <b>H.C. Dietz, M.D.</b>										
PHYSICIAN'S NAME (Type) <b>H.C. Dietz, M.D.</b>										
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>9-28-56</b>		22c. NAME OF CEMETERY OR CREMATORIAL <b>St. Michael's Cemetery Frostburg</b>		22d. LOCATION (City, town, or county) <b>Frostburg, Md.</b>		(State) <b>Md.</b>		
23. FUNERAL DIRECTOR'S SIGNATURE <b>Reinhardt Montague</b>		Hafer Funeral Home 23 E. Main, Frostburg, Md.		24a. REC'D BY REGISTRAR <b>9-28-56</b>		24b. REGISTRAR'S SIGNATURE <b>Dee Slaney, M.P.</b>				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8938

## CERTIFICATE OF DEATH

108927  
9

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Allegany</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Allegany</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frostburg</b>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Lonaconing</b>		d. STREET ADDRESS <b>Island Street</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Miners Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <b>Laura</b>		First <b>Jane</b>	Middle <b>Jane</b>	Last <b>Spiker</b>	4. DATE OF DEATH <b>September 21 1956</b>	Month <b>September</b>	Day <b>21</b>	Year <b>1956</b>
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <b>9/8/64</b>	9. AGE (In years last birthday) <b>92 yrs.</b>	IF UNDER 1 YEAR Months <b>0</b>	IF UNDER 24 HRS. Days <b>0</b>	Hours <b>0</b>	Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House Work</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (State or foreign country) <b>Midland, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>John Kelly</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Andrew Spiker "Son"</b>		Address <b>Lonaconing, Md.</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Suffocation				INTERVAL BETWEEN ONSET AND DEATH <b>1 hour</b>		
2521 Conditions, if any, which gove rise to immediate cause (a), stating the under-lying cause lost. (b)		Thyroid adenoma enlargement				2 weeks		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Arteriosclerosis</b>		Malnutrition				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Malnutrition</b>						
20c. TIME OF INJURY Hour o. m. p. m.	Month 19	Day	Year	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <b>Lonaconing</b>	(County) <b>Allegany</b>	(State) <b>Md.</b>
21. I certify that I attended the deceased from <b>Aug 6</b> , 1956, to <b>Sept 21</b> , 1956, that I last saw the deceased alive on <b>Sept 21</b> , 1956, and that death occurred at <b>8:30 P.M.</b> from the causes and on the date stated above. ACTUAL SIGNATURE <b>Leslie R. Miles, Jr.</b> M.D.								
ADDRESS (Street, city or town, state) <b>Lonaconing, Md.</b> DATE SIGNED								
PHYSICIAN'S NAME (Type) <b>Leslie R. Miles, Jr., M.D.</b>								
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>9/24/56</b>	22c. NAME OF CEMETERY OR CREMATORIUM <b>Beeman Cemetery</b>		22d. LOCATION (City, town, or county) <b>Lonaconing</b>		(State) <b>Md.</b>		
23. FUNERAL DIRECTOR'S SIGNATURE <b>George Eichhorn</b>		ADDRESS <b>Lonaconing, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>9/24/56</b>		24b. REGISTRAR'S SIGNATURE <b>Allie Nancy N. Lee</b>		

BUREAU V. S.

OCT 1 1955

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

08928

## 8911 CERTIFICATE OF DEATH

Reg. Dist. No. 4

## INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-35 10M

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN	Allegany Cumberland	MARYLAND LENGTH OF STAY (In this place)	STATE Maryland CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
HOSPITAL OR INSTITUTION OR STREET ADDRESS	Allegany County Infirmary		
3. NAME OF DECEASED (First) (Middle) (Last)		4. DATE (Month) (Day) (Year) OF DEATH September 11, 56	
S. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Single	8. DATE OF BIRTH 2/18/1893
9. AGE last birthday 63 yrs.	10. KIND OF BUSINESS OR INDUSTRY Retired Clerk--2nd Nat. Bank	11. BIRTHPLACE (State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME John Stanton	14. MOTHER'S MAIDEN NAME Katherine Kerwan		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) No.	16. SOCIAL SECURITY NO.		
17. INFORMANT & ADDRESS Allegany County Infirmary Records			
18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
422.2 IMMEDIATE CAUSE (A) Pulmonary Hypertension			
ANTECEDENT CAUSE(S) DUE TO Chronic Myocarditis			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) DUE TO Cerebral Hemorrhage			
(C) Left Hemiplegia			
INTERVAL BETWEEN ONSET AND DEATH 36 hrs.			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION		
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	
21e. INJURY OCCURRED M. at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from 5/18/55, 19....., to 9/11/56, 19....., that I last saw the deceased alive on 9/11/56, 19....., and that death occurred at 7:10 P.M. from the causes and on the date stated above. SIGNATURE Dr. James E. McLean, M.D. DATE SIGNED 9/12/56			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 9/15/56	
24. REC'D. BY REGISTRAR Sept. 14, 1956		REGISTRAR'S SIGNATURE Winter R. Faust, M.D.	
25. FUNERAL DIRECTOR'S SIGNATURE Charles L. George		ADDRESS Cumberland, Maryland	

STATE DEPARTMENT OF HAWAII - NATURALIZATION

CERTIFICATE OF DEATH

DECEASED PERSON  
NAME: MARY LEE  
DATE OF DEATH: APRIL 15, 1956

AGE AT DEATH: 56

CAUSE OF DEATH: HEART DISEASE

TIME OF DEATH:

5 P.M.

AM

PLACE OF DEATH:

HOME

NAME OF DOCTOR:

DR. JAMES R. HOPKINS

DECEASED PERSON'S LAST KNOWN ADDRESS:

1100 KAHANAMOKU DRIVE, HONOLULU, HAWAII

BUREAU Y.

1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
8912 CERTIFICATE OF DEATH

08929

Reg. Dist. No.

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours of death. It may be retained by the hospital or attending physician.  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in, it should be filed with the register prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/55

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>		c. LENGTH OF STAY IN 1b <b>7 HRS. 20 MIN</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>MARYLAND</b>		b. COUNTY <b>MARYLAND</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MEMORIAL HOSPITAL</b> <b>CUMBERLAND, MD. MEMORIAL &amp; WARWICK AVES.</b>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First <b>ALFRED</b>	Middle <b>Henry</b>	Last <b>STEVENS</b>	4. DATE OF DEATH <b>SEPTEMBER 22 1956</b>	Month <b>SEPTEMBER</b>	Day <b>22</b>	Year <b>1956</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 30, 1917</b>		9. AGE (In years lost birthday) <b>39</b> yrs.	IF UNDER 1 YEAR Months <b>0</b>	IF UNDER 24 HRS. Days <b>0</b>	Hours <b>0</b>	Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Mutual Clerk</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Racing Guild</b>		11. BIRTHPLACE (State or foreign country) <b>Massachusetts</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>		
13. FATHER'S NAME <b>Henry John Stevens</b>			14. MOTHER'S MAIDEN NAME <b>Martha Marion Scott</b>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>026-14-5277</b>		17. INFORMANT <b>Mrs. Martha M. Stevens 4335 Alan Drive Balto. Md.</b>		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]  PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1</b> DUE TO  Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>Coronary occlusion</b> (b) DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH <b>12 hrs.</b>				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour a. m. p. m.	Month <b>Sept.</b>	Day <b>19</b>	Year <b>1956</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>M.D. 128 Union St, Cumberland, Md.</b>	20f. (City or town) <b>Hull</b>	(County) <b>Massachusetts</b>	(State) <b>Massachusetts</b>	
21. I certify that I attended the deceased from <b>9/21</b> , 1956, to <b>9/22</b> , 1956, that I last saw the deceased alive on <b>9/22</b> , 1956, and that death occurred at <b>6:30 AM</b> , from the causes and on the date stated above.					ADDRESS (Street, city or town, state) <b>M.D. 128 Union St, Cumberland, Md.</b>		DATE SIGNED <b>Sept. 22, 1956</b>		
ACTUAL SIGNATURE <b>George M. Simons</b>		PHYSICIAN'S NAME (Type) <b>GEORGE M. SIMONS</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>9/25/56</b>	22c. NAME OF CEMETERY OR CREMATORIUM <b>Hull Village Cemetery</b>			22d. LOCATION (City, town, or county) <b>Hull, Massachusetts</b>		(State) <b>Massachusetts</b>		
23. FUNERAL DIRECTOR'S SIGNATURE <b>H. Wayne George</b>		ADDRESS <b>Cumberland, Maryland</b>			24a. REC'D BY REGISTRAR <b>Sept. 22, 1956</b>		24b. REGISTRAR'S SIGNATURE <b>Ed. Frank, M. D.</b>		

BUREAU V. 2

SEP 26 1956

RECEIVED

Within corporate limits

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8913

## CERTIFICATE OF DEATH

08950

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>WEST VIRGINIA</b>		b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>		c. LENGTH OF STAY IN 1b <b>12 HRS. 45 MIN.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RIDGELEY</b>		d. STREET ADDRESS <b>28 KNOBLEY STREET</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MEMORIAL HOSPITAL MEMORIAL &amp; WARWICK AVES.,</b>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print)	First <b>ROBERT</b>	Middle <b>Adam</b>	Last <b>TABLER</b>	4. DATE OF DEATH	Month <b>SEPTEMBER</b>	Day <b>18</b>	Year <b>1956</b>
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5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>MARCH 22 1884</b>	9. AGE (In years lost birthday) <b>72 yrs.</b>	IF UNDER 1 YEAR Months <b>0</b>	IF UNDER 24 HRS. Days <b>0</b>	Hours <b>0</b>	Min. <b>0</b>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired yard conductor</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>W. Md. Rwy.</b>	11. BIRTHPLACE (State or foreign country) <b>MARYLAND Cumberland</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
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13. FATHER'S NAME <b>Augustus TABLER</b>	14. MOTHER'S MAIDEN NAME <b>SAVILLA GLOVER</b>	Address
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No,</b>	16. SOCIAL SECURITY NO. <b>705-10-8558</b>	17. INFORMANT <b>Mr. Roland S. Tabler Ridgeley, W. Va.</b>

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>581.0</b> Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) Due to (c) Due to	Cirrhosis. Arteriosclerosis ?	INTERVAL BETWEEN ONSET AND DEATH <b>6 months</b>
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19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		

20c. TIME OF INJURY Month, Day, Year Hour a. m.      p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
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21. I certify that I attended the deceased from <b>8-30- 1955</b> , to <b>9-18- 1955</b> , that I last saw the deceased alive on <b>9-18- 1955</b> , and that death occurred at <b>6:40 P.M.</b> from the causes and on the date stated above.	ADDRESS (Street, city or town, state) <b>Howard Tolson 1225 Center, Cumberland, Md.</b>	DATE SIGNED <b>9-19-56</b>
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ACTUAL SIGNATURE <b>Howard Tolson</b>	PHYSICIAN'S NAME (Type) <b>Howard L. Tolson</b>
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22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>9/21/56</b>	22c. NAME OF CEMETERY OR CREMATORIUM <b>Rose Hill Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Cumberland, Maryland</b>
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23. FUNERAL DIRECTOR'S SIGNATURE <b>H. Wayne George</b>	ADDRESS <b>Cumberland, Maryland</b>	24a. REC'D BY REGISTRAR <b>Sept. 21 1956</b>	24b. REGISTRAR'S SIGNATURE <b>W. H. Hanby, M.D.</b>
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BUREAU

SEP 24 19

REGELV

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08951

Within corporate limits

8914

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH a. COUNTY <b>Allegany</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) b. STATE <b>Maryland</b>		b. COUNTY <b>Allegany</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>		c. LENGTH OF STAY IN lb <b>33 years</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>		d. STREET ADDRESS <b>908 Bedford St.</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>908 Bedford St.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <b>FRANK</b>		First	Middle	Last	4. DATE OF DEATH <b>Sept. 22,</b>	Month	Day	Year <b>19 56</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH <b>Mar. 21, 1902</b>	9. AGE (In years lost birthday) <b>54 yrs.</b>	IF UNDER 1 YEAR Months <b>No</b>	IF UNDER 24 HRS. Days <b>00</b>	Hours <b>00</b>	Min. <b>00</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Car Sales Operator</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Auto Industry</b>		11. BIRTHPLACE (State or foreign country) <b>Terra Alta, W. Va.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
13. FATHER'S NAME <b>M. N. Taylor</b>		14. MOTHER'S MAIDEN NAME <b>Elizabeth Whitehair</b>		Address				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>214 34 1390</b>		17. INFORMANT <b>Edith M. Taylor</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b> DUE TO <b>260X</b> Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. } (b) <b>Hyper tension and</b> DUE TO } (c) <b>Diabetes Mellitus</b> INTERVAL BETWEEN ONSET AND DEATH <b>Unmeasurable</b> 5 yrs.		
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Obesity -</b>		20c. TIME OF INJURY Month, Day, Year Hour a. m. — 19 p. m. — 20d. INJURY OCCURRED White Not white at work <input type="checkbox"/> at work <input checked="" type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <b>4/7/56</b> , 19, to <b>9/22/56</b> , 19, that I last saw the deceased alive on <b>9/21/56</b> , 19, and that death occurred at <b>9a</b> M, from the causes and on the date stated above. ACTUAL SIGNATURE <b>R. J. Williams M.D.</b>		ADDRESS (Street, city or town, state) <b>Cumberland, Md.</b>		DATE SIGNED <b>9/23/56</b>				
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>9-25-56</b>		22c. NAME OF CEMETERY OR CREMATORIAL <b>Hill Crest Burial Park</b>		22d. LOCATION (City, town, or county) <b>Cumberland, Md.</b> (State)		
23. FUNERAL DIRECTOR'S SIGNATURE <b>Byron Kight</b>		ADDRESS <b>Cumberland, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>Sept. 25 1956</b>		24b. REGISTRAR'S SIGNATURE <b>W. R. Trotter, M.D.</b>		

STATE DEPARTMENT OF HEALTH—SAVANNAH, GA

CERTIFICATE OF DEATH

RECEIVED

BUREAU V. S.

SEP-28 1956

RECEIVED

**TO HOSPITAL** ( ) **ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## Within corporate limits MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

18952

DR. HIMMELWRIGHT

8915

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH a. COUNTY ALLEGANY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 5 DAYS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL		e. STREET ADDRESS 635 SHRIVER AVENUE	
3. NAME OF DECEASED (Type or print) R. LEWIS		4. DATE OF DEATH Month SEPTEMBER Day 27 Year 1956	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JANUARY 10, 1884
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED		10b. KIND OF BUSINESS OR INDUSTRY Self Employed	11. BIRTHPLACE (State or foreign country) XX XX XX XX GEORGIA Alexandria, Va. U.S.A.
13. FATHER'S NAME Valentine Taylor		14. MOTHER'S MAIDEN NAME XX XX XX XX XX XX XX XX Virginia Watkins	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 217-10-1068	17. INFORMANT MEMORIAL HOSPITAL - CUMBERLAND, MD.
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <b>PART I. DEATH WAS CAUSED BY:</b> IMMEDIATE CAUSE (a) 422.1 DUE TO Congestive Heart Failure - Uremia INTERVAL BETWEEN ONSET AND DEATH 2 days Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) DUE TO Arteriosclerotic Cardio Vascular Disease. - (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Pulmonary Fibrosis - Bronchial Asthma			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>July</u> , 1954, to <u>Sept</u> , 1956, that I last saw the deceased alive on <u>Sept 26</u> , 1956, and that death occurred at <u>2:29 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE DR. O. HIMMELWRIGHT		ADDRESS (Street, city or town, state) M.D. 133 Va Ave, Cumberland, Md 9/27/56	
PHYSICIAN'S NAME (Type) DR. O. HIMMELWRIGHT		DATE/SIGNED 9/27/56	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 9/29/56	22c. NAME OF CEMETERY OR CREMATORIUM Rose Hill Cemetery	22d. LOCATION (City, town, or county) (State) Cumberland, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE John J. Hayes, Cumberland, Md.		ADDRESS	24a. REC'D BY REGISTRAR Oct 1, 1956
			24b. REGISTRAR'S SIGNATURE W. R. Tracy, M.D.

BUREAU V. 2

OCT 3 1956

RECEIVED

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death: Page 4  
 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the offending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Within corporate limits  
 Hodge

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8916

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

08933

DR. RANSOM

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b>		b. COUNTY <b>ALLEGANY</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>		c. LENGTH OF STAY IN lb <b>1 DAY</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>		d. STREET ADDRESS <b>133 OAK ST.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MEMORIAL HOSPITAL</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <b>BABY BOY</b>		First	Middle	Lost	4. DATE OF DEATH <b>TRUE</b>	Month	Day	Year	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>SEPT. 20, 1956</b>	9. AGE (In years last birthday) yrs. <b>0</b>	IF UNDER 1 YEAR Months <b>0</b>	IF UNDER 24 HRS. Days <b>0</b>	Hours <b>0</b>	Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>none</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>none</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>DONALD CHARLES TRUE</b>		14. MOTHER'S MAIDEN NAME <b>JEAN EMILY CLONTZ</b>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO.		17. INFORMANT		Address <b>MEMORIAL HOSPITAL-MEMORIAL &amp; WARWICK AVES.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Intravascular hemorrhage</b> DUE TO <b>Shock - undate septic</b> Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) <b>Prolonged (36hr) labor</b> DUE TO (c)									
INTERVAL BETWEEN ONSET AND DEATH									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour a. m. p. m.		Month <b>9</b>	Day <b>19</b>	Year <b>1956</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Cumberland, Md.</b>	20f. (City or town) <b>Cumberland</b>	(County) <b>Md.</b>	(State) <b>Md.</b>
21. I certify that I attended the deceased from <b>9/20/56</b> to <b>9/21/56</b> , that I last saw the deceased alive on <b>9/21/56</b> , and that death occurred at <b>2:35 PM</b> , from the causes and on the date stated above.									
ACTUAL SIGNATURE <b>WR Hedges</b>		ADDRESS (Street, city or town, state) <b>Cumberland, Md.</b> DATE SIGNED <b>4/22/56</b>							
PHYSICIAN'S NAME (Type)									
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4-20-56</b>		22c. NAME OF CEMETERY OR CREMATORIY <b>Hillcrest Burial Pk.</b>		22d. LOCATION (City, town, or county) <b>Cumberland, Md.</b>		(State) <b>Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>James F. Scarpelli, Cumberland, Md.</b>		ADDRESS <b>James F. Scarpelli, Cumberland, Md.</b>		24a. REC'D BY REGISTRAR <b>4/22/56</b>		24b. REGISTRAR'S SIGNATURE <b>W. H. Hedges, M.D.</b>			

BUREAU V.  
RECEIVE

SEP 26 1956

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08934

Within corporate limits:

8917

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>W.V.A.</b>		b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>		c. LENGTH OF STAY IN 1b <b>2 HRS. 10 MIN.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>WILEY FORD</b>				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MEMORIAL HOSPITAL MEMORIAL &amp; WARWICK AVES.</b>		d. STREET ADDRESS				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <b>Baby</b>		First	Middle	Last	4. DATE OF DEATH <b>WAGONER</b>	Month	Day	Year
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>SEPT. 24, 1956</b>	9. AGE (In years last birthday) yrs. <b>2</b>	10. IF UNDER 1 YEAR Months <b>2</b>	11. IF UNDER 24 HRS. Days <b>10</b>	Hours <b>0</b>	Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>CUMBERLAND, MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
13. FATHER'S NAME <b>PAUL WAGONER</b>		14. MOTHER'S MAIDEN NAME <b>DARLENE M. GROVE</b>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Paul Wagner Wiley Ford, W.Va.</b>		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		DUE TO <i>One month</i>		INTERVAL BETWEEN ONSET AND DEATH <i>24-26 mos</i>				
Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying cause last.</u> (b) DUE TO (c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)				
21. I certify that I attended the deceased from _____, 19_____, to _____, 19_____, that I last saw the deceased alive on _____, 19_____, and that death occurred at 8:55 AM, from the causes and on the date stated above. ACTUAL SIGNATURE: <i>Fuller B. Whitworth</i> M.D.				ADDRESS (Street, city or town, state)		DATE SIGNED		
PHYSICIAN'S NAME (Type) <b>FULLER B. WHITWORTH</b>								
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>9-25-56</b>		22c. NAME OF CEMETERY OR CREMATORIAL <b>Davis Memorial Cem.</b>		22d. LOCATION (City, town, or county) <b>Cumberland, Md.</b> (State)		
23. FUNERAL DIRECTOR'S SIGNATURE <b>James F. Scarpelli</b>		ADDRESS <b>Cumberland, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>Sept. 25, 1956</b>		24b. REGISTRAR'S SIGNATURE <b>W. R. Dratz, M.D.</b>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

SEP 28 1956

RECEIVED

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. You may retain it in the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by you, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

118935

DR. W.F. WILLIAMS

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>PENNSYLVANIA</b>		b. COUNTY <b>SOMERSET</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>		c. LENGTH OF STAY IN 1b <b>4 DAYS</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SOMERSET</b>		75 X - 3		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MEMORIAL HOSPITAL</b>		d. STREET ADDRESS <b>678 EAST MAIN STREET</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)	First <b>MERLE</b>	Middle <b>Y.</b>	Last <b>WALKER</b>	4. DATE OF DEATH	Month <b>SEPTEMBER</b>	Day <b>2</b>	Year <b>19 56</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH <b>MARCH 19, 1888</b>	9. AGE (In years last birthday) <b>60 yrs.</b>	IF UNDER 1 YEAR Months <b>0</b>	IF UNDER 24 HRS. Days <b>0</b>	Hours <b>0</b>	Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED CLERK</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Hardware</b>		11. BIRTHPLACE (State or foreign country) <b>PENNSYLVANIA</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>MILLARD WALKER</b>			14. MOTHER'S MAIDEN NAME <b>MILINDA HAY</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>	16. SOCIAL SECURITY NO. <b>174-16-1858</b>		17. INFORMANT <b>MEMORIAL HOSPITAL - CUMBERLAND, MARYLAND</b>	Address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <span style="float: right;">INTERVAL BETWEEN ONSET AND DEATH</span>								
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Chronic rheumatic heart disease</b>								
416X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Chronic Nephritis (uremia)</b> 3 days.								
DUE TO (b) DUE TO (c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <b>Cumberland</b>	(County) <b>Md.</b>	(State) <b>Md.</b>		
21. I certify that I attended the deceased from <b>7-18</b> , 19 <b>56</b> to <b>9-2 - 1956</b> that I last saw the deceased alive on <b>9-1-1956</b> , and that death occurred at <b>1:10 AM</b> , from the causes and on the date stated above.								
ADDRESS (Street, city or town, state) <b>Wm. F. Williams, Cumberland Md.</b>								
DATE SIGNED <b>9-3-56</b>								
ACTUAL SIGNATURE <b>Wm. F. Williams, Cumberland Md.</b>								
PHYSICIAN'S NAME (Type) <b>DR. W.F. WILLIAMS</b>								
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Sept. 4, 1956</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Fritz Cemetery</b>		22d. LOCATION (City, town, or county) <b>Somerset, Penna.</b>		
23. FUNERAL DIRECTOR'S SIGNATURE <b>James F. Scarpelli, Cumberland, Md.</b>								
ADDRESS								
24a. REQ'D BY REGISTRAR DATE <b>Sept. 4, 1956</b>								
24b. REGISTRAR'S SIGNATURE <b>W.R. Tracy, M.D.</b>								

## CERTIFICATE OF DEATH

CHALMAN

C. C.

243 X 6

DECEASED PERSON

NAME OF DECEASED PERSON

BUREAU X-1

SEP 6 1956

REGISTRY

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8939

## CERTIFICATE OF DEATH

08936

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Allegany</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Allegany</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frostburg</b>		c. LENGTH OF STAY IN 1b <b>65 yrs.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frostburg</b>		d. STREET ADDRESS <b>377 Welsh Hill</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>377 Welsh Hill</b>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Mary</b>		First <b>Mary</b>	Middle <b>Jane</b>	Last <b>Ware</b>	4. DATE OF DEATH <b>9-23-1956</b>	Month <b>9-</b>	Day <b>23</b>	Year <b>1956</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 30th, 1871</b>	9. AGE (In years last birthday) <b>85</b>	IF UNDER 1 YEAR Months <b>0</b>	IF UNDER 24 HRS. Days <b>0</b>	Hours <b>0</b>	Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House work</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (State or foreign country) <b>Lonaconing, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>			
13. FATHER'S NAME <b>Samuel Taylor</b>		14. MOTHER'S MAIDEN NAME <b>Anna Eliza T Jeffries</b>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Daughter</b> <b>Mrs. John Brodbeck, 377 Welsh Hill, Frostburg</b>		Address <b>Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arterio Sclerosis</b> DUE TO <b>450.0</b>						INTERVAL BETWEEN ONSET AND DEATH <b>several years</b>			
Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) DUE TO (c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Pneumonia</b>		20c. TIME OF INJURY Month, Doy, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Sept 23, 1956</b> , to <b>Sept 23, 1956</b> that I last saw the deceased alive on <b>Sept 22, 1956</b> , and that death occurred at <b>9:51 AM</b> , from the causes and on the date stated above. ACTUAL SIGNATURE <b>Wom C. Lane</b> PHYSICIAN'S NAME (Type) <b>Wom C. Lane</b>									
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>9-26-1956</b>		22c. NAME OF CEMETERY OR CREMATORIAL <b>Frostburg Memorial</b>		22d. LOCATION (City, town, or county) <b>Frostburg</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>Hager Funeral Home, Frostburg, Md.</b>		ADDRESS <b>15M 9 SS</b>		24a. REC'D BY REGISTRAR <b>9-26-56</b>		24b. REGISTRAR'S SIGNATURE <b>John H. Roe</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2013-07-20 10:40

OCT 1 1956

REGELIV EOU

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
8919 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08937

Reg. Dist. No.

1. PLACE OF DEATH  
a. COUNTY

Allegany

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Cumberland

c. LENGTH OF STAY IN lb

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

D.O.A. at the Sacred Heart Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)

a. STATE

Pa.

b. COUNTY

Somerset

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Wellersburg

75x-3

d. STREET ADDRESS

e. IS RESIDENCE  
ON A FARM?  
YES  NO

3. NAME OF  
DECEASED  
(Type or print)

First  
Charles

Middle  
Theodore

Last  
Weimer

4. DATE  
OF  
DEATH

Month  
Sept.

Day  
4  
Year  
1956

5. SEX

male

6. COLOR OR RACE

white

7. MARRIED  NEVER MARRIED

WIDOWED  DIVORCED

8. DATE OF BIRTH

Oct. 7-1895

9. AGE (In years  
last birthday)

60  
yrs.

10. IF UNDER 1 YEAR

Months  
Days

11. IF UNDER 24 HRS.

Hours  
Min.

10a. USUAL OCCUPATION (Give kind of work done  
during most of working life, even if retired)

Coal miner

10b. KIND OF BUSINESS OR INDUSTRY

Mining coal

11. BIRTHPLACE (State or foreign country)

Meyersdale, Pa.

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Theodore Weimer

14. MOTHER'S MAIDEN NAME

Alfreta Bittner

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Type or unknown)

7/6

16. SOCIAL SECURITY NO.

17. INFORMANT

Address

(wife) Jennie K. Weimer, Wellersburg, Pa.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a)

Intracranial hemorrhage due to a fractured-sudden  
shull, right temporal parietal region.

Conditions, if any, which  
gave rise to immediate cause  
(a), stating the underlying  
cause lost.

DUE TO

(b)

DUE TO

(c)

About one ton of rock & coal fell down on him.

INTERVAL BETWEEN  
ONSET AND DEATH

19. WAS AUTOPSY  
PERFORMED?  
YES  NO

20a. EXTERNAL CAUSE WAS  
PRIMARY  OR CONTRIBUTING   
CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

Working in a coal mine, rock & coal fell down on him.

20c. TIME OF INJURY Month, Day, Year

Hour

10.30 a.m.—9-4

20d. INJURY OCCURRED

While

at work

Not white  
at work

20e. PLACE OF INJURY (Home, farm,  
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

Coal mine

Wellersburg, Somerset Pa.

21. I certify that I took charge of the remains described above, held an Autopsy , Inspection , Inquiry , and find that death resulted from: Natural causes , Accident , Suicide , Homicide , Undetermined cause .

ACTUAL  
SIGNATURE

H. V. Deming M.D.

M.D. CHIEF MEDICAL EXAMINER

ASSISTANT MEDICAL EXAMINER

DEPUTY MEDICAL EXAMINER

DATE SIGNED

EXAMINER'S  
NAME (Type)

H. V. Deming M.D.

Sept. 4-1956

22a. BURIAL, CREMATION,  
REMOVAL (Specify)

Burial

22b. DATE THEREOF

Sept. 7, 1956

22c. NAME OF CEMETERY OR CREMATORIUM

White Oak Cemetery

22d. LOCATION (City, town, or county)

Wellersburg, Pennsylvania.

(State)

23. FUNERAL DIRECTOR'S SIGNATURE

Harvey H. Zeigler, Hyndman, Pennsylvania.

ADDRESS

24a. REC'D BY REGISTRAR

Sept. 5, 1956

24b. REGISTRAR'S SIGNATURE

W.L. Frantz, M.D.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enter the date and hour when it was signed. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be retained for your files.  
FORWARDED TO THE CHIEF MEDICAL EXAMINER'S OFFICE along with Farm PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

RECEIVED

DEPARTMENT OF STATE  
WILSON LIBRARY

LIBRARY OF CONGRESS

RECEIVED  
6 SEP 1956

RECEIVED

BUREAU V.

8940

## CERTIFICATE OF DEATH

Reg. Dist. No. 9

1. PLACE OF DEATH a. COUNTY <b>Allegany</b>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>MARYLAND</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frostburg</b>		c. LENGTH OF STAY IN 1b <b>3 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Miners Hospital</b>		e. STREET ADDRESS <b>275 Welsh Hill</b>	
3. NAME OF DECEASED (Type or print) <b>LOUIS</b>		First <b>M.</b>	Middle <b>WHITACRE</b>
4. DATE OF DEATH <b>Sept. 27, 1956</b>	Month <b>Sept.</b>	Day <b>27</b>	Year <b>1956</b>
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH <b>3-8-1903</b>
		WIDOWED <input type="checkbox"/>	DIVORCED <input type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Truck driver</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>General hauling</b>	
11. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>George W. Whitacre</b>		14. MOTHER'S MAIDEN NAME <b>Emma Abell</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. 17. INFORMANT <b>220-10-2718 Mrs. Beulah Whitacre, Frostburg, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Rheumatic Heart disease</b> DUE TO <b>416X</b>		INTERVAL BETWEEN ONSET AND DEATH <b>20 yrs</b>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO <b>Congestive Heart Failure</b>			
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>6</b>
20f. (City or town) <b>Frostburg</b>		(County) <b>Md.</b>	
(State) <b>MD.</b>			
21. I certify that I attended the deceased from _____ 6 _____, 1956, to _____ 9/27, 1956, that I last saw the deceased alive on _____ 9/27, 1956, and that death occurred at 10:38 P.M., from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <b>134 E 17th St Frostburg, Md.</b>	
ACTUAL SIGNATURE <b>John C. Devers</b>		DATE SIGNED <b>9/27/56</b>	
PHYSICIAN'S NAME (Type) <b>John C. Devers</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>9-30-56</b>	
22c. NAME OF CEMETERY OR CREMATORIAL <b>F'bg. Memorial Park</b>		22d. LOCATION (City, town, or county) <b>Frostburg, Md.</b>	
(State)			
23. FUNERAL DIRECTOR'S SIGNATURE <b>J. R. Durst,</b>		ADDRESS <b>Frostburg, Md.</b>	
24a. REC'D BY REGISTRAR <b>Doris Stancy H. Ross</b>		24b. REGISTRAR'S SIGNATURE <b>DATE 9-30-56</b>	

WISCONSIN STATE GOVERNMENT OF HERTH-SAWINOWIE 16

CERTIFICATE OF DEATH

REGISTRATION

NAME

BUREAU V. S.

OCT 3 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4

Within corporate limits

may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
Page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with  
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08939

DR. XPAK

8920  
W.F.WILLIAMS

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH o. COUNTY <b>ALLEGANY</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>	c. LENGTH OF STAY IN 1b <b>33 DAYS</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MEMORIAL HOSPITAL</b>		d. STREET ADDRESS <b>18 N. ALLEGANY ST.</b>				
3. NAME OF DECEASED (Type or print)	First <b>ETHEL</b>	Middle <b>D</b>	Last <b>WHITE</b>			
4. DATE OF DEATH <b>JA SEPT. 17, 1956</b>	Month <b>JA</b>	Day <b>17</b>	Year <b>1956</b>			
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>JAN. 18, 1902</b>			
9. AGE (In years last birthday) <b>54 yrs.</b>		10. IF UNDER 1 YEAR Months <b>0</b>	11. IF UNDER 24 HRS. Hours <b>0</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>housewife.</i>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	11. BIRTHPLACE (State or foreign country) <b>MD.</b>			
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>H.H.DICKEY</b>				
14. MOTHER'S MAIDEN NAME <b>ANNIE R. ROBERTS</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				
16. SOCIAL SECURITY NO. <b>—</b>		17. INFORMANT <b>MEMORIAL HOSPITAL MEMORIAL &amp; WARWICK AVES.</b>	Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>420.1</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <i>hours</i>				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Firm malefactor. St. bland fibula</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>8-15-1956</b>	20f. (City or town) <b>—</b>	(County) <b>—</b>	(State) <b>—</b>
21. I certify that I attended the deceased from <b>8-15-1956</b> to <b>9-17-1956</b> that I last saw the deceased alive on <b>9-17-1956</b> , and that death occurred at <b>3:30 P.M.</b> from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <b>John F. Williams, Cumberland Md.</b>		DATE SIGNED <b>9-18-56</b>		
ACTUAL SIGNATURE <i>John F. Williams, Cumberland Md.</i>						
PHYSICIAN'S NAME (Type) <b>DR. W.F.WILLIAMS</b>						
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>Sept. 20-1956</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Rose Hill Cemetery</b>		22d. LOCATION (City, town, or county) <b>Cumberland Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Louis Stein, Cumberland Md.</i>		ADDRESS		24a. REC'D. BY REGISTRAR <b>Sept. 20, 1956</b>	24b. REGISTRAR'S SIGNATURE <b>W.R. Gratz, M.D.</b>	
VS A15 (4) ISM 9/55						

STATE OF HAWAII - DEPARTMENT OF EDUCATION

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08940

DR. HODGES

8921

CERTIFICATE OF DEATH

Reg. Dist. No.

4

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>		c. LENGTH OF STAY IN 1b <b>11 HRS. 45 MIN.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MEMORIAL HOSPITAL</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>	
d. STREET ADDRESS <b>113 MARY STREET</b>		d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <b>BABY</b>	Middle <b>GIRL</b>	Last <b>WILSON</b>
4. DATE OF DEATH	Month <b>SEPTEMBER</b>	Day <b>7</b>	Year <b>1956</b>
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>SEPTEMBER 6, 1956</b>
9. AGE (In years lost birthday) yrs. <b>None</b>	10. IF UNDER 1 YEAR Months <b>0</b>	11. IF UNDER 24 HRS. Days <b>0</b>	12. IF UNDER 24 HRS. Hours <b>45</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <b>CUMBERLAND, MARYLAND</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>DAVID E. WILSON</b>	14. MOTHER'S MAIDEN NAME <b>EDNA L. GRAPES</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>	16. SOCIAL SECURITY NO. <b>None</b>	17. INFORMANT <b>MEMORIAL HOSPITAL - CUMBERLAND, MD.</b>	Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Prematurity</b> DUE TO 761.5 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) <b>Premature separation</b> DUE TO (c) <b>of Placenta</b> <b>13 hrs</b>			
INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m.	Month 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Sept 6, 1956</b>
20f. (City or town) <b>Sept 7, 1956</b>	(County)	(State)	
21. I certify that I attended the deceased from <b>Sept 6, 1956</b> to <b>Sept 7, 1956</b> that I last saw the deceased alive on <b>Sept 6, 1956</b> , and that death occurred at <b>6:10 AM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>W.R. Hodges</b>	ADDRESS (Street, city or town, state) <b>Cumberland, Md.</b> DATE SIGNED <b>Sept 8, 1956</b>		
PHYSICIAN'S NAME (Type) <b>DR. W.R. HODGES</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>9-8-56</b>	22c. NAME OF CEMETERY OR CREMATORIAL <b>Davis Memorial Cem.</b>	22d. LOCATION (City, town, or county) <b>Cumberland, Md.</b> (State)
23. FUNERAL DIRECTOR'S SIGNATURE <b>James F. Scarpelli</b>	ADDRESS <b>Cumberland, Md.</b>	24a. REC'D BY REGISTRAR <b>Sept 8, 1956</b>	24b. REGISTRAR'S SIGNATURE <b>W.L. Gratz, M.D.</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death; Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED - STATE GOVERNMENT - HONOLULU - HAWAII  
CERTIFICATE OF DEATH

BUREAU Y. &

SEP 13 1956

RECEIVED

Within corporate limits

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4

may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

ITEM 13, FILM  
Unit G587,  
1/13/84 er

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08941

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH a. COUNTY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)	
Allegany				a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 56 yrs		b. COUNTY Allegany	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 208 Carroll Street				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland Md. 208	
3. NAME OF DECEASED (Type or print)		First Frank	Middle A	Last Wolfhouse	4. DATE OF DEATH Sept 4 1956
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug 15, 1874
9. AGE (In years (last birthday) 83 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Auditor		10b. KIND OF BUSINESS OR INDUSTRY Bookkeeping.		11. BIRTHPLACE (State or foreign country) New Baltimore Pa	
12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME BERNARD Hause		14. MOTHER'S MAIDEN NAME Adelie Miller			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No.		16. SOCIAL SECURITY NO. 213-16-9538		17. INFORMANT John Wolfhouse 208 Carroll St	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		Address			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 260x		myocardial collapse			
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		3 day			
(b)		Chronic myocarditis, Gen. Anasarca			
DUE TO (c)		1 1/2 yrs			
		Diabetes mellitus			
		10 yrs			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month. Day. Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> At work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Sept 4, 1956, to Sept 4, 1956, that I last saw the deceased alive on Sept 4, 1956, and that death occurred at 49 M, from the causes and on the date stated above. ACTUAL SIGNATURE Physician's Name (Type) Lyle R. Everhart		ADDRESS (Street, city or town, state) 36 Greene St Cumberland Md.			
DATE SIGNED					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Sept 7, 1956		22c. NAME OF CEMETERY OR CREMATORIUM St. Peter & Paul's Cemetery	
22d. LOCATION (City, town, or county) Cumberland		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE Loren Stein Jr.		ADDRESS Cumb. Md.		24c. REC'D BY REGISTRAR DATE - 6/16/1956	
				24b. REGISTRAR'S SIGNATURE W.L. Tracy M.D.	

WISCONSIN STATE DEPARTMENT OF HEALTH - SANITATION  
CERTIFICATE OF DEATH

BUREAU V. S.

SEP 10 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
8923 CERTIFICATE OF DEATH

08942

Reg. Dist. No. 4

1. PLACE OF DEATH o. COUNTY <b>Allegany</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) o. STATE <b>Maryland</b>		b. COUNTY <b>Allegany</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>		c. LENGTH OF STAY IN 1b <b>Benj. Banneker Homes, Apt. 5B</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>		d. STREET ADDRESS <b>Benj. Banneker Homes, Apt. 5B</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Benj. Banneker Homes, Apt. 5B</b>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <b>JOHN</b>		First <b>OMNEY</b>	Middle <b>WOODSON</b>	Last <b>WOODSON</b>	4. DATE OF DEATH <b>Sept. 3, 1956</b>	Month <b>Sept.</b>	Day <b>3</b>	Year <b>1956</b>
S. SEX <b>Male</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <b>Apr. 6, 1892</b>	9. AGE (in years last birthday) <b>64</b> yrs.	IF UNDER 1 YEAR Months <b>0</b>	IF UNDER 24 HRS. Days <b>0</b>	Hours <b>0</b>	Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Waiter, Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Shrine Country Club</b>		11. BIRTHPLACE (State or foreign country) <b>Lewisburg, West Virginia USA</b>		12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME <b>Silas Woodson</b>				14. MOTHER'S MAIDEN NAME <b>Mandie Jackson</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <b>220-03-7631</b>		17. INFORMANT <b>Benj. Banneker Homes Mrs. Nettie Woodson, Cumberland, Maryland</b>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Chronic myocarditis</b>						INTERVAL BETWEEN ONSET AND DEATH <b>3 years</b>		
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. <b>Chronic rheumatism</b>		(b) DUE TO <b>5 years</b>		(c)				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED White Not while of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <b>Aug 29, 1956</b> , to <b>Aug 30, 1956</b> , that I last saw the deceased alive on <b>Aug 30, 1956</b> , and that death occurred at <b>4 AM</b> , from the causes and on the date stated above. ACTUAL SIGNATURE <b>R. W. Trevaskis, Sr.</b>		ADDRESS (Street, city or town, state) <b>Cumberland, Maryland</b> DATE SIGNED <b>9/4/1956</b>						
PHYSICIAN'S NAME (Type) <b>R. W. Trevaskis, Sr.</b>								
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Sept. 6, 1956</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Woodlawn Cemetery</b>		22d. LOCATION (City, town, or county) <b>Cumberland, Maryland</b> (State)		
23. FUNERAL DIRECTOR'S SIGNATURE <b>John J. Hafer, Cumberland, Maryland</b>		ADDRESS <b>230 Baltimore Ave.</b>		24d. REC'D BY REGISTRAR <b>Sept. 5, 1956</b>		24e. REGISTRAR'S SIGNATURE <b>W. R. Frank, M.D.</b>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
 page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with  
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF NEW YORK  
CERTIFICATE OF DEATH

BUREAU V.

SEP 6 1956

RECEIVED

Within corporate limits

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8924

## CERTIFICATE OF DEATH

118943

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Allegany</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Allegany</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>		c. LENGTH OF STAY IN 1b <b>15 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>		d. STREET ADDRESS <b>123 S. Smallwood St.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Sacred Heart Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)		First <b>Otho</b>	Middle <b>Leonard</b>	Last <b>Wymer</b>	4. DATE OF DEATH	Month <b>September</b>	Day <b>14</b>	Year <b>1956</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <b>Apr. 10, 1899</b>	9. AGE (In years last birthday) <b>57</b>	IF UNDER 1 YEAR IF UNDER 24 HRS. Months <b>5</b>	Days <b>0</b>	Hours <b>0</b>	Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Conductor</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Western Md. R.R.</b>		11. BIRTHPLACE (State or foreign country) <b>W. Va., Hamilton</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>Marshal Wymer</b>		14. MOTHER'S MAIDEN NAME <b>Ida Poling</b>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No,</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Mrs. Genevieve Wymer</b>		Address <b>Cumberland, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>541.0</b>		Coronary Occlusion				INTERVAL BETWEEN ONSET AND DEATH <b>30 ± 45 min.</b>			
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b)		DUE TO		due to dense ulcer (operator.)					
(c)		DUE TO							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour a. m. p. m.	Month 19	Day	Year	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <b>1055. Erie</b>	(County) <b>Cumberland</b>	(State) <b>Md.</b>	
21. I certify that I attended the deceased from <b>8-30-56</b> , to <b>9-14-56</b> , that I last saw the deceased alive on <b>9-14-56</b> , and that death occurred at <b>443P</b> M, from the causes and on the date stated above.									
ACTUAL SIGNATURE <i>C. L. George</i>	M.D.		ADDRESS (Street, city or town, state) <b>1055. Erie</b>		DATE SIGNED <b>9-15-56</b>				
PHYSICIAN'S NAME (Type) <b>Charles L. George</b>	<b>C. L. George</b>		<b>C. L. George</b>		<b>C. L. George</b>				
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>9/17/56</b>	22c. NAME OF CEMETERY OR CREMATORIUM <b>Philos Cemetery</b>		22d. LOCATION (City, town, or county) <b>Westernport, Maryland</b>		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE <b>Charles L. George</b>		ADDRESS <b>Cumberland, Maryland</b>		24a. REC'D BY REGISTRAR <b>Sept. 15, 1956</b>		24b. REGISTRAR'S SIGNATURE <b>W. Frank M.D.</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED  
BUREAU A. S.

SEP 19 1956

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08944

8925

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 14 DAYS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First MARY	Middle LULA	Last YINGLING
4. DATE OF DEATH	Month SEPTEMBER	Day 18	Year 1956
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 9-2-1876
8. AGE (In years lost birthday) 80 yrs.	9. IF UNDER 1 YEAR Months	10. IF UNDER 24 HRS. Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Smithsburg, Maryland		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME P. JAMES R. MITTEN		14. MOTHER'S MAIDEN NAME JULIA ANN WARNER	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? Yes, no, or unknown No, If yes, give war or dates of service		16. SOCIAL SECURITY NO. None	
17. INFORMANT MEMORIAL HOSPITAL		Address AVENUES MEMORIAL & WARWICK	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 331X DUE TO General Hemorrhage. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 2603 (b) DUE TO Generalized Arteriosclerosis (c)		INTERVAL BETWEEN ONSET AND DEATH 2 weeks.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Diabetes mellitus		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While Not while at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 9-17-1956 to 9-18-1956 that I last saw the deceased alive on 9-17-1956, and that death occurred at 1:05 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE DR. W.F. WILLIAMS		ADDRESS (Street, city or town, state) DATE SIGNED Dr. W.F. Williams, Cumberland, Md. 9-18-56	
PHYSICIAN'S NAME (Type)		22d. LOCATION (City, town, or county) (State)	
22e. BURIAL, CREMATION, REMOVAL (Specify) Burial		22f. DATE THEREOF 9/20/56	
22g. NAME OF CEMETERY OR CREMATORIAL Rose Hill Cemetery		22h. REGISTRAR'S SIGNATURE	
23. FUNERAL DIRECTOR'S SIGNATURE Charles L. George Cumberland, Maryland		24a. REC'D BY REGISTRAR DATE 9-20-56	

**BUREAU V. S.**

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
8926 CERTIFICATE OF DEATH

08945

Reg. Dist. No.

**TO HOSPITAL & ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. It may be relayed by the hospital or attending physician.  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Allegany</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>		c. LENGTH OF STAY IN 1b <b>3 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Sacred Heart Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <b>Joseph</b>	Middle <b>Wesley</b>	Last <b>Young</b>
4. DATE OF DEATH <b>9/ 14 1956</b>	Month <b>9</b>	Day <b>14</b>	Year <b>1956</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 21, 1889</b>
9. AGE (In years last birthday) <b>67 yrs.</b>	10. IF UNDER 1 YEAR Months <b>0</b>	11. IF UNDER 24 HRS. Days <b>0</b>	12. IF UNDER 24 HRS. Hours <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Minister</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Preaching</b>	11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>John Young</b>	14. MOTHER'S MAIDEN NAME <b>Mary Andrews</b>	Address	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>	16. SOCIAL SECURITY NO. <b>220-34-1368</b>	17. INFORMANT <b>Chart Mrs. Mary Young, Cumberland, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)  <b>Raynford arteri aneurysm</b>			
DUE TO  <b>443X</b>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b)  <b>Generalized arteriosclerosis</b>			
DUE TO  <b>(c)</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)  <b>Hypertensive cardiovascular disease</b>			
INTERVAL BETWEEN ONSET AND DEATH <b>4 hours -</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Hour o. m. p. m. 19	20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>Sept 14, 1956</b> , to <b>Sept 14, 1956</b> , that I last saw the deceased alive on <b>Sept 13, 1956</b> , and that death occurred at <b>Cumberland, Md.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>William P. James</b> M.D. <b>141 N. Center St., Cumberland, Md.</b> DATE SIGNED <b>9-14-56</b>			
ACTUAL SIGNATURE <b>William P. James</b>	PHYSICIAN'S NAME (Type) <b>William P. James</b>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>Sept 16 1956</b>	22c. NAME OF CEMETERY OR CREMATORIUM <b>Rose Hill Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Cumberland, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Right</b>	ADDRESS <b>Cumberland, Md.</b>	24a. REC'D BY REGISTRAR <b>Sept. 16, 1956</b>	24b. REGISTRAR'S SIGNATURE <b>W.L. Haunty, M.D.</b>

DEPARTMENT OF DEFENSE  
CERTIFICATE OF DATA

BUREAU V. S.

SEP 19 1956

RECEIVED